

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10172

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Monocacy Hall Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Mollie

May

Akers

4. DATE
OF
DEATH

308 East Third Street

September

7,

19 61

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

September 8, 1874

9. AGE (In years
at birthday)

86

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Frederick County, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel M. Summers

14. MOTHER'S MAIDEN NAME

Sarah Ann Micheals

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

217-10-0653

17. INFORMANT

Mr. Milton E. Adkers 308 E. Third St. Fred. Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

450.0 DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last. (b)

DUE TO

(c)

GENERALIZED ARTERIOSCLEROSIS

INTERVAL BETWEEN
ONSET AND DEATH

10+ yrs.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

FRACTURED HIP BRONCHOPNEUMONIA

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/4, 1960, to 9/16, 1961, that (I) (we) last
saw the deceased alive on 9/6, 1961, and that death occurred at 3:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Richard C. Reynolds

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.9-7-1961
22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Dr. Richard C. Reynolds

M.D.

9 East Church Street Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 9-9-1961

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

(State)

Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE
Robert E. Dailey & Son

ADDRESS

25a. REC'D BY REGISTRAR DATE SEP 13 '61
25b. REGISTRAR'S SIGNATURE
Christine S. Kraus

57-301

57-305

(M)

Wolfeboro

Bethel

Wolfeboro

Wolfeboro

Exact

Wolfeboro

Source: Milt and Bob

and patient list recorded

✓ Redington

Small

✓

Difficult

OB 1981 ✓ Redington

Small Blown

✓ Mrs. Evelyn Cushing Richards

Small

Small

Small and normal

Normal Small

✓ Mrs. 30 small OB 600 pounds no complications 1980-1981 - - - - -

✓ Small and normal 1980-1981 - - - - -

2

100-1-

✓ Mrs. 30 small OB 600 pounds no complications 1980-1981 - - - - -

Small and normal

1980-1981 Small

Small

Small

Small and normal

not a problem

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10177

10173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If more than 24 hours elapse, the physician or attending physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Vindobona Convelescent Home		d. STREET ADDRESS Route 7	
3. NAME OF DECEASED (Type or print) Thomas Stephens Anderson		First Thomas	Middle Stephens
4. DATE OF DEATH Sept. 13 1961	Last Anderson	Month Sept.	Day 13
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Jan. 14-1877
9. AGE (In years last birthday) 84 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Kent County- Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME William Anderson		
14. MOTHER'S MAIDEN NAME Mary Jane Stephens		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-24-3111		17. INFORMANT Donald T. Anderson-(Son)-Washington- D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) 450.0 Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. Senility DUE TO Generalized arteriosclerosis DUE TO 5 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour a.m. p.m. 19	Month, Day, Year 9-12-1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work Not While at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 220 N. Market St.-Frederick- Md.
20f. (City or town) Frederick	(County) Maryland	(State) Md.	19. WAS AUTOPSY PERFORMED? NO
21. I certify that (I) (this hospital) attended the deceased from 9-1-1961 to 9-13-1961 , that (I) (we) last saw the deceased alive on 9-12-1961 , and that death occurred 10:30A from the causes and on the date stated above.			
22a. SIGNATURE Rex R. Martin		ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 9-14-61
22c. PHYSICIAN'S NAME (Type) Rex R. Martin- M.D.		M.D.	DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-16-1961	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Dailey's Funeral Home- Frederick- Maryland		ADDRESS By E. J. Whitmore	23d. LOCATION (City, town or county) Frederick- Maryland
25a. REC'D BY REGISTRAR SEP 15 '61		25b. REGISTRAR'S SIGNATURE Charles S. Knott	(State)
DATE			

Thlaspi
caerulescens

13 E-8 22 -1-9
AGE: 05

408-105

$\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

• 11 -minibus - 31. total. 1092

bestätigt - Schreiber - und Lassen erfüllen

FOR STATE
HEALTH DEPT.

M

TO DIVISION OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10174

1. PLACE OF DEATH

a. COUNTY

FREDERICK

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FREDERICK

c. LENGTH OF STAY IN IB

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

County Jail

3. NAME OF
DECEASED
(Type or print)

First W
FRANCIS . W

Middle

Last

4. DATE
OF
DEATH

Month 9 - 26
Day Year
19 61

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

5-21-1922

9. AGE (In years
at birthday)
yrs.

39

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

WORLD WAR II FIREMAN B+O.R.R. CO

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FRANK A. BARKER

14. MOTHER'S MAIDEN NAME

MAMIE DUNN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(See Item 16, if deceased in service)

16. SOCIAL SECURITY NO.

17. INFORMANT

MRS. MARGARET BARKER, BRUNSWICK, MD

Address

WORLD WAR II

IMMEDIATE CAUSE (e)

307X

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

Acute Cerebral Edema

Delirium Tremens

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

4 hr.

2 days

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY
Hour e.m.
p.m.

Month, Day, Year
19
While at work Not While at work

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection , Inquiry , and in my opinion
death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED
9/27/61

ACTUAL
SIGNATURE

B.O. Thomas

EXAMINER'S
NAME (Type)

B.O. THOMAS

REMOVAL (Specify)

BURIAL

DATE THEREOF

9-29-61

22b. DATE THEREOF

23. FUNERAL DIRECTOR

NAME

B. Lee Feltz

ADDRESS

BRUNSWICK, MD

22c. NAME OF CEMETERY OR CREMATORIUM

ARLINGTON NAT.

22d. LOCATION (City, town, or country)

FORT MYER, VIRGINIA

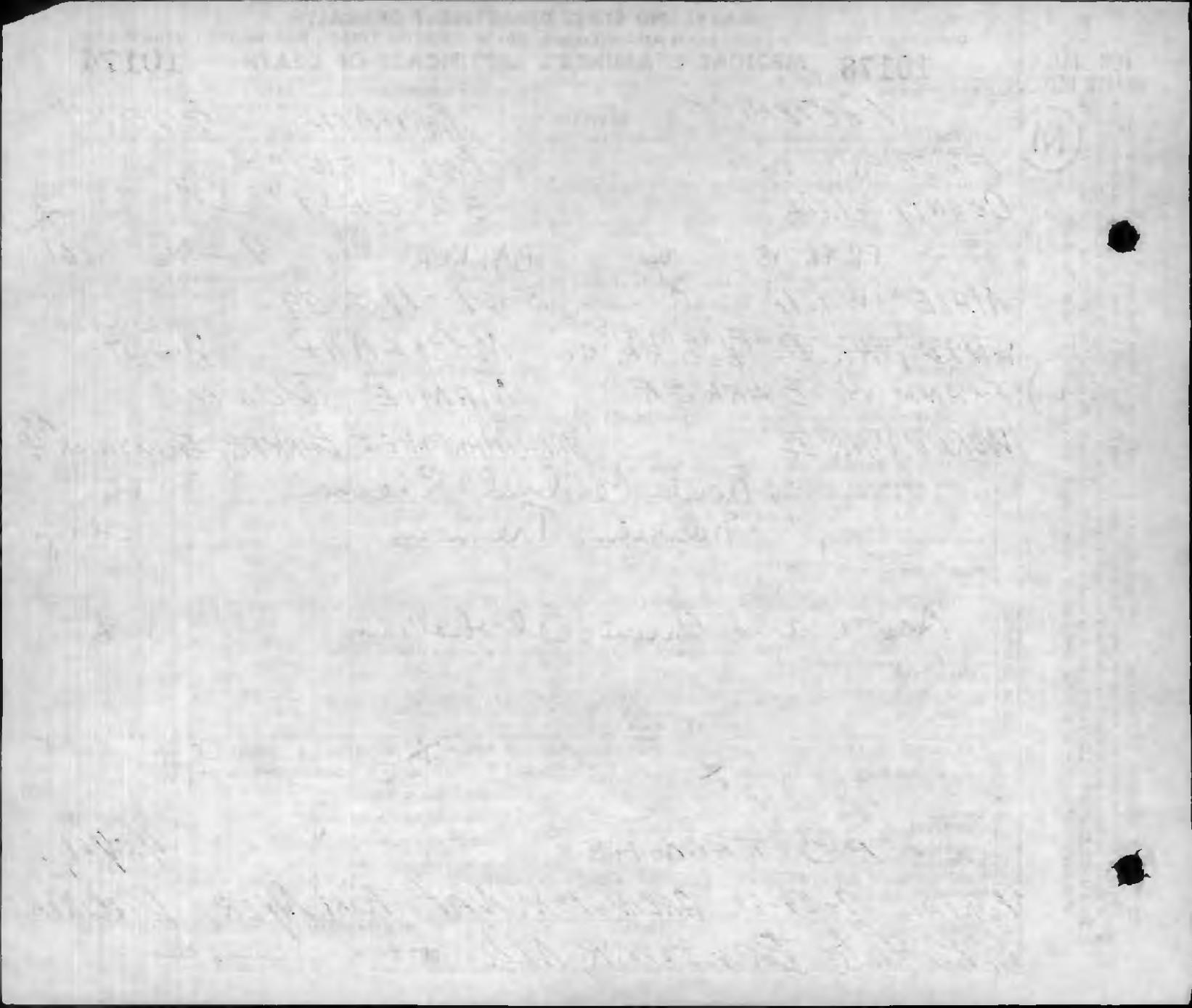
(State)

24e. REC'D BY REGISTRAR

OCT 2 '61

25. REGISTRAR'S SIGNATURE

Arthur S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

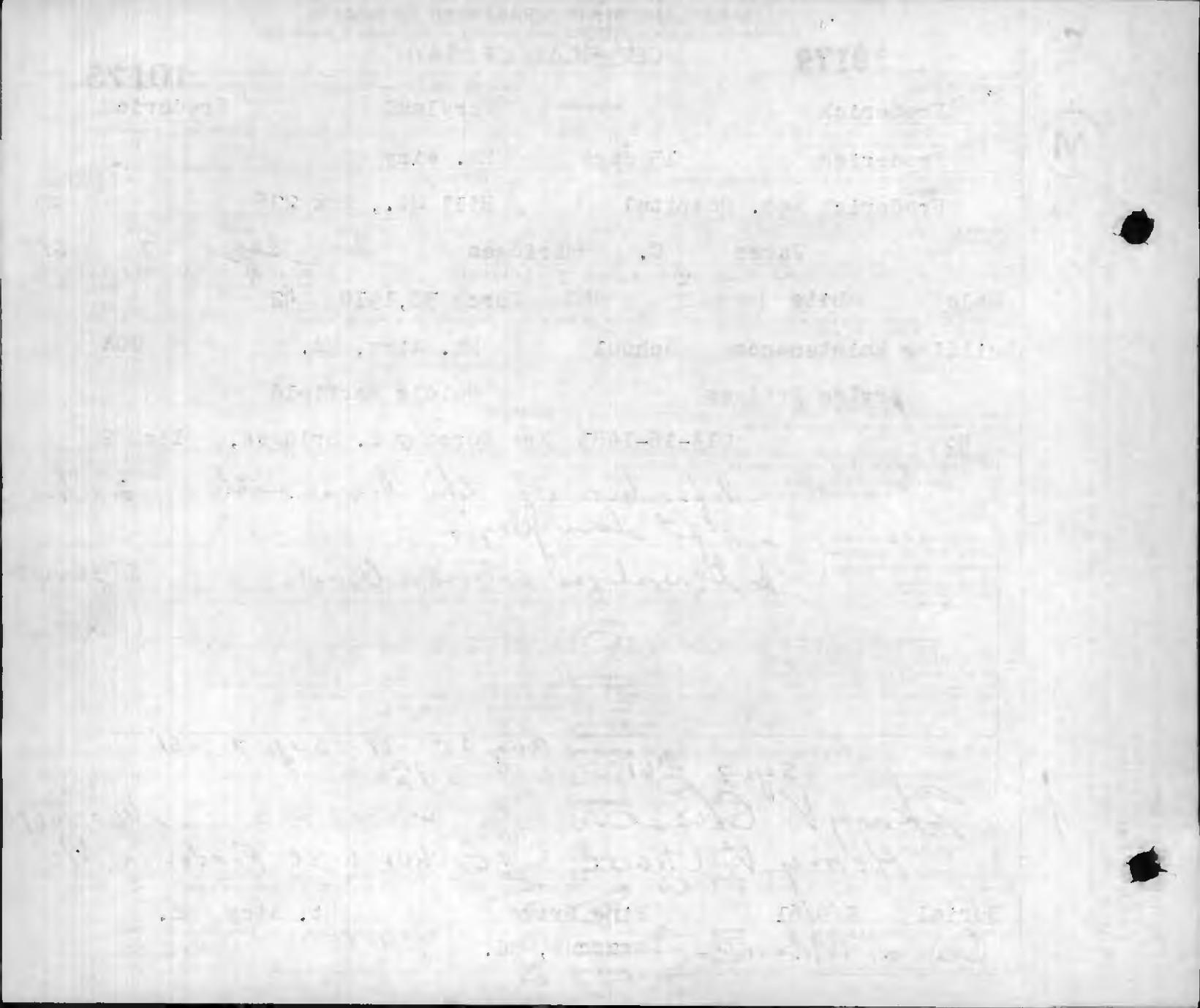
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10179

10175

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		d. STREET ADDRESS Hill St., Box 226			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James C. Bridges		First James	Middle C.	Last Bridges	4. DATE OF DEATH Sep 7 1961	Month Sep	Day 7	Year 1961	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1919	9. AGE (In years lost birthday) 42 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Maintenance		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Mt. Airy, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Arvlee Bridges				14. MOTHER'S MAIDEN NAME Goldie Warfield					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-1483		17. INFORMANT Mrs Dorothy L. Bridges, Item 2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X <i>Infarction of the brain with left hemiplegia.</i> INTERVAL BETWEEN ONSET AND DEATH 2 weeks									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO # <i>& Generalized arteriosclerosis</i> DUE TO 5 years +									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 25 1961 to Sep 7 1961 , that (I) (we) last saw the deceased alive on Sep 7 1961 , and that death occurred at 7:50 AM , from the causes and on the date stated above.									
22a. SIGNATURE Henry V. Chase		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sep 7 1961					
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 46 Church St. Frederick Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/9/61		23c. NAME OF CEMETERY OR CREMATORIAL Pine Grove		23d. LOCATION (City, town, or county) Mt. Airy, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molanworth		ADDRESS Damascus, Md.		25a. RECEIVED BY REGISTRAR SEP 11 1961		25b. REGISTRAR'S SIGNATURE Walter S. Thomas		DATE	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

10180

CERTIFICATE OF DEATH

10176

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Chester	Middle Wright	Last Brown
4. DATE OF DEATH Sept. 22 1961	Month Sept.	Day 22	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 21, 1901
9. AGE (In years last birthday) 59 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm Rental	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Samuel Walter Brown			14. MOTHER'S MAIDEN NAME Emma A. Wright
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-36-6846	17. INFORMANT Mrs. Evelyn R. Brown-Same as Item #2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Acute coronary thrombosis (c) Atherosclerotic Heart Disease			
INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 11 Diabetes mellitus 216 beauty			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sep 12 1961 to Sep 22 1961 , that (I) (we) last saw the deceased alive on Sep 22 1961 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Henry V. Chase		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/22/61
22c. PHYSICIAN'S NAME (Type) Henry V. Chase	22d. ADDRESS 4E Church St Frederick, Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 25, 1961	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 27 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10181

10177

1. PLACE OF DEATH a. COUNTY FREDERICK				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 5 Days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED [Type or print] LYDIA		First *A*	Middle ALICE	Last Brown	4. DATE OF DEATH Dec 11, 1871	Month Sept	Day 33	Year 1961
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 11, 1871	9. AGE (In years lost birthday) yrs. 89	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Everhart				14. MOTHER'S MAIDEN NAME Sarah Ropp				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Norman Fry -Same as Item #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic heart disease (c) DUE TO 10 yrs								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Levettsville	(County) Virginia	(State) MD	
21. I certify that (I) (JR Poirier) attended the deceased from Sept 10, 1961 to Sept 23, 1961 , that (I) (JR Poirier) last saw the deceased alive on Sept 19, 1961 , and that death occurred 9:30 P.M. from the causes and on the date stated above								
22a. SIGNATURE JR Poirier				22b. DATE SIGNED 9/24/61				
22c. PHYSICIAN'S NAME (Type) JR Poirier				22d. ADDRESS 801 Toll House Ave, FREDERICK, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 26, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Levettsville, Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 27 '61	25b. REGISTRAR'S SIGNATURE O. R. Etchison	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10182

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

Days(5)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

CHARLES

EDWARD

BRUCHHEY

4. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

June 13, 1895

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Self Employed

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Howard B. Bruchey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or details of service)

Yes

WWI

16. SOCIAL SECURITY NO.

214-42-1565

17. INFORMANT

Mrs. Helen Starr, Frederick, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first.

DUE TO

(b)

Congestive Heart failure

DUE TO

acute coronary thrombosis

(c)

cardiovascular heart disease

INTERVAL BETWEEN
ONSET AND DEATH

5 days

5 days

5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not While at work 20d. INJURY OCCURRED While at work
Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 12, 1957 to Sep. 6, 1961, that (I) (we) last saw the deceased alive on Sep. 5, 1961, and that death occurred 12:25A.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Henry V. Chase, M.D.

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
9/8/1961

22d. ADDRESS

East Church Street, Frederick, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

Sept. 9, 1961

23b. DATE THEREOF

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Maryland

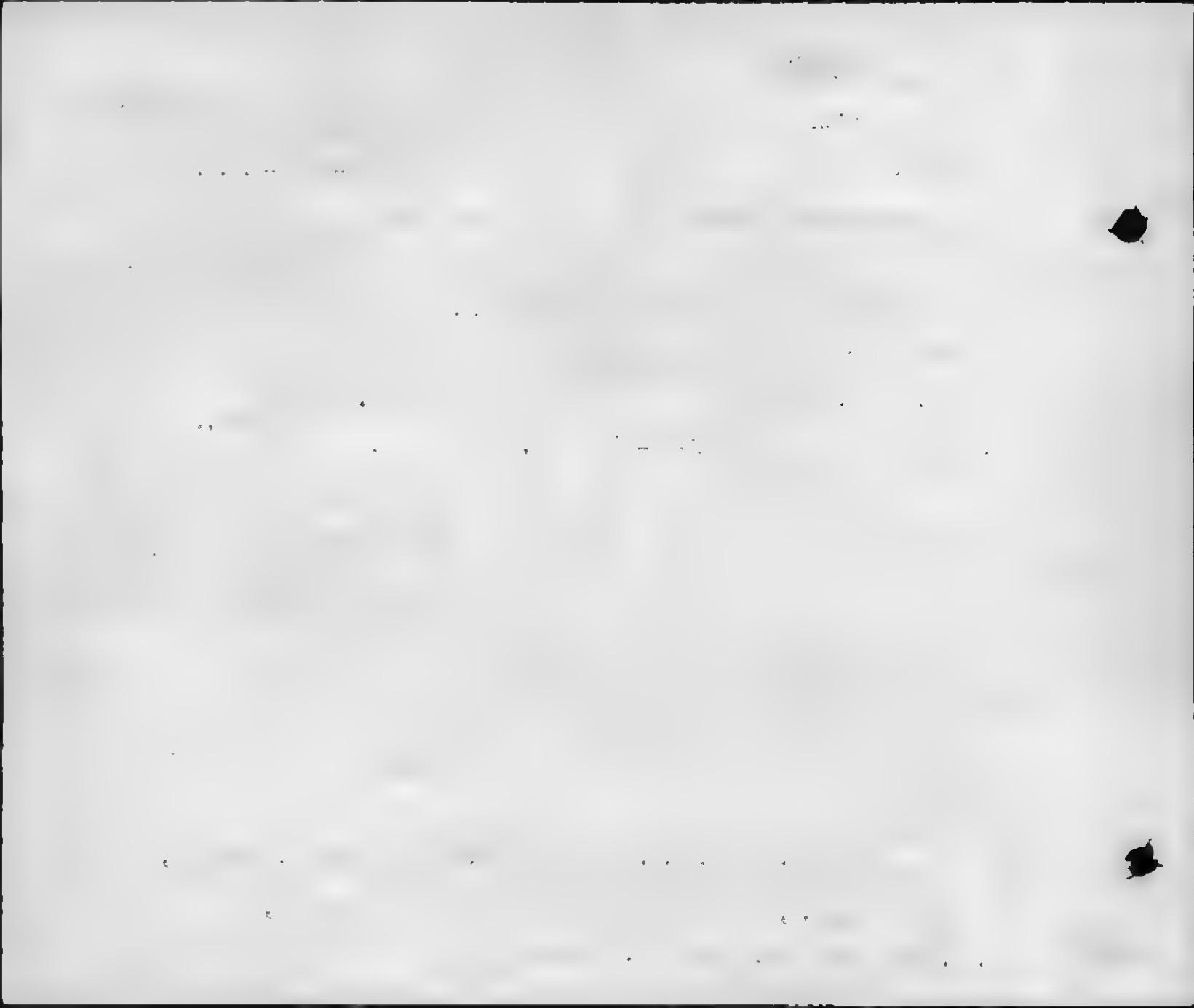
25a. REC'D. BY REGISTRAR

SEP 11 '61

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Chase



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending Physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

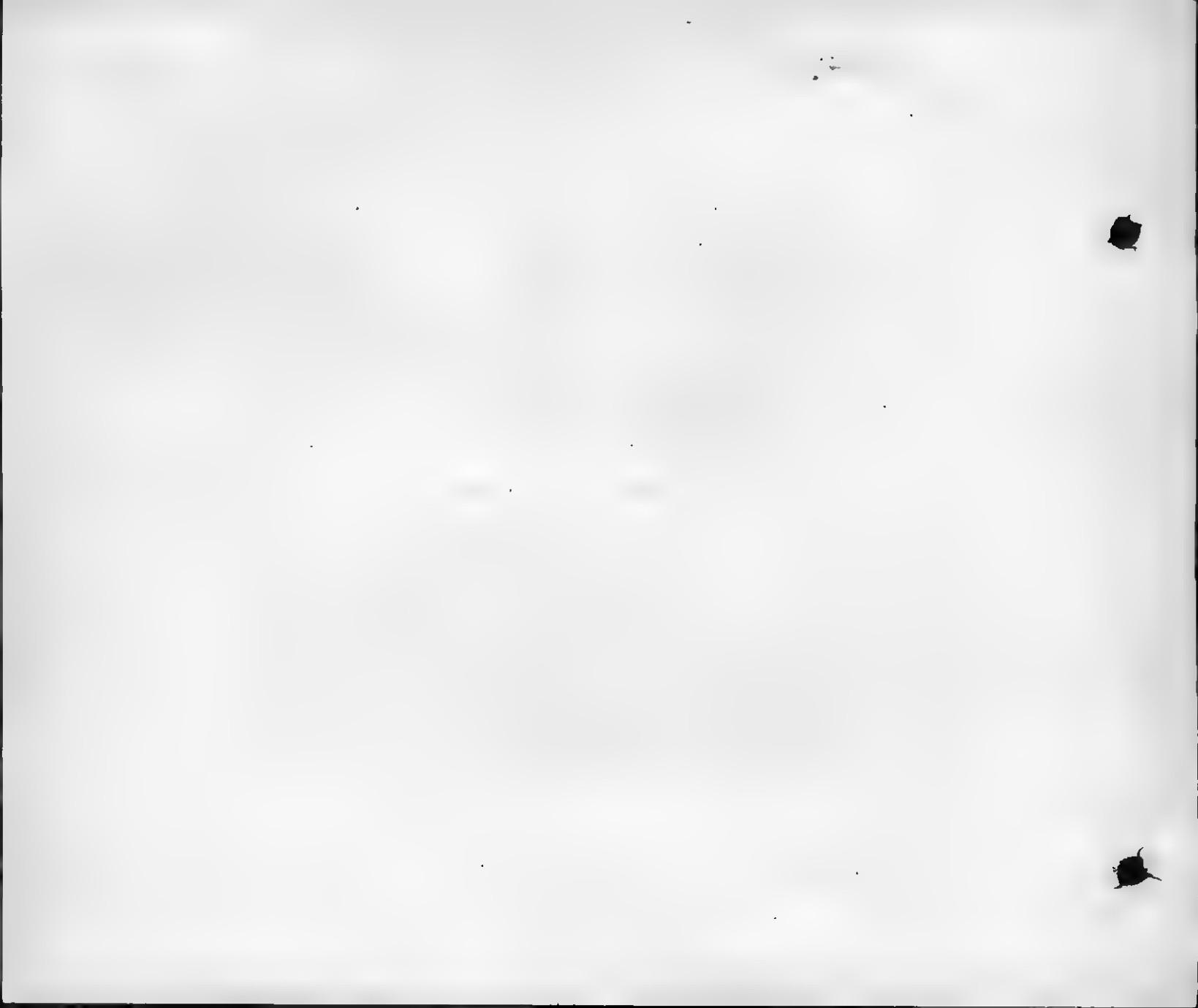
10183

Item 2 Film 6291

10/2/61 mb

10179

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
FREDERICK				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		Md.	
FREDERICK		Life		FREDERICK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MONOCACY Hall Nursing Home		2 East 4th St.			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Viola Belle Carlisle					Sept. 21 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
F		W		Aug 19 - 1873	68 yrs.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Nurse and		Nursing Care		Frederick County, Md., U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Selby		Sarah Ricketts		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes, no, or unknown		577-6-2972		Mr. Franklin H. Carlisle	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH			
4-4-4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		PULMONARY EMPHYSEMA, Obstructive years COR PULMONALE years			
DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
Hour a. m. p. m.		19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from Aug 1961 to Sept 1961 that (I) () lost saw the deceased alive on 21 Sept 1961, and that death occurred at 7:15PM, from the causes and on the date stated above					
22a. SIGNATURE		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
J.R.Poirier					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
J.R. POIRIER		801 Toll House Ave, FREDERICK, Md.			
23a. BURIAL, CREMATON REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM	
Burial		9-23-61		7th Avenue Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
McKinney		Indiana Rd.		DATE SEP 25 '61	Arthur S. Koenig



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

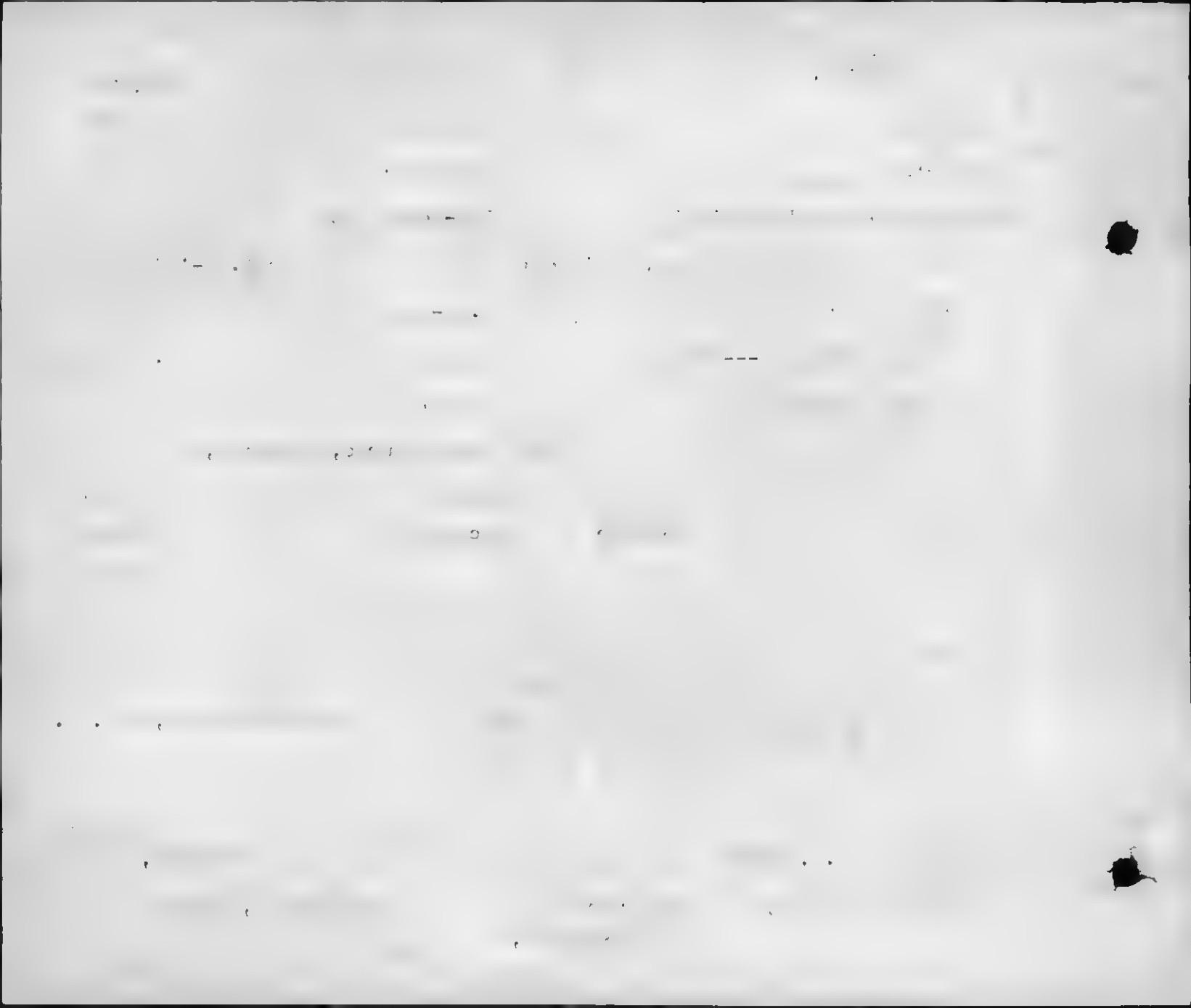
1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b		b. COUNTY		Frederick			
Frederick		2 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural — Jefferson Md.			
Frederick Memorial Hosp.)				d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Charles		Wilbur	Carson Jr.		Sep	8	1961		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 15, 1936	24 yrs	Months	Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
dairyman		Farm		Maryland		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
C. Wilbur Carson Sr.		May Chick							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		212-38-9549		Mrs. Wilbur Carson Jr.		Jefferson Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		5-10 min.							
492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Acute pulmonary edema							
{ DUE TO (b) Acute viral myocarditis		2 days							
{ DUE TO (c) Viral pneumonia		2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that (I) (this hospital) attended the deceased from Sep 8, 1961, to Sep 8, 1961, that (I) (we) last saw the deceased alive on Sep 8, 1961, and that death occurred at 8P M, from the causes and on the date stated above.		22b. DATE SIGNED							
22a. SIGNATURE		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	Sep 9, 1961		
Henry V. Chase									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
Henry V. Chase		4E Church St. Frederick, Md.							
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county)		(State)	
Burial		Sept. 11, 1961		Mt. Olivet Cem.		Frederick		Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lucian K. Falcone New Market Md.				DATE SEP 13 '61		Cathleen S. Thomas			



1
FOR STATE
HEALTH DEPT.

File is necessary,
please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20b Film 295 9-22-61 ams		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
10185		MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital							
3. NAME OF DECEASED (Type or print) Mary		First	Middle	4. DATE OF DEATH 115-Record St			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Feb. 17-1886	Month	Day	Year	Month
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeping--Own home		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME John Chiswell		11. BIRTHPLACE (State or foreign country) Maryland		75 yrs		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank and date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Susie Gott		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Mrs Eleanor Burke, Frederick, Md					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock		INTERVAL BETWEEN ONSET AND DEATH 3 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Shock					
DUE TO Multiple		Fractures					
DUE TO Fractures		INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While attempting to remove leaves from top of porch roof-Fell about 15 feet					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 pm. 9/19/61		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Braddock Heights, Fred. Co. Md	
(County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B.O.Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) B.O.Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/61		22c. NAME OF CEMETERY OR CREMATORIUM Monocacy		22d. LOCATION (City, town, or county) Beallsville, Maryland	
23. FUNERAL DIRECTOR Constance C. Hilton		ADDRESS Barnesville, Md		24a. REC'D BY REGISTRAR DATE SEP 15 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Knobell	
VS. A15ME 5M 7/59							



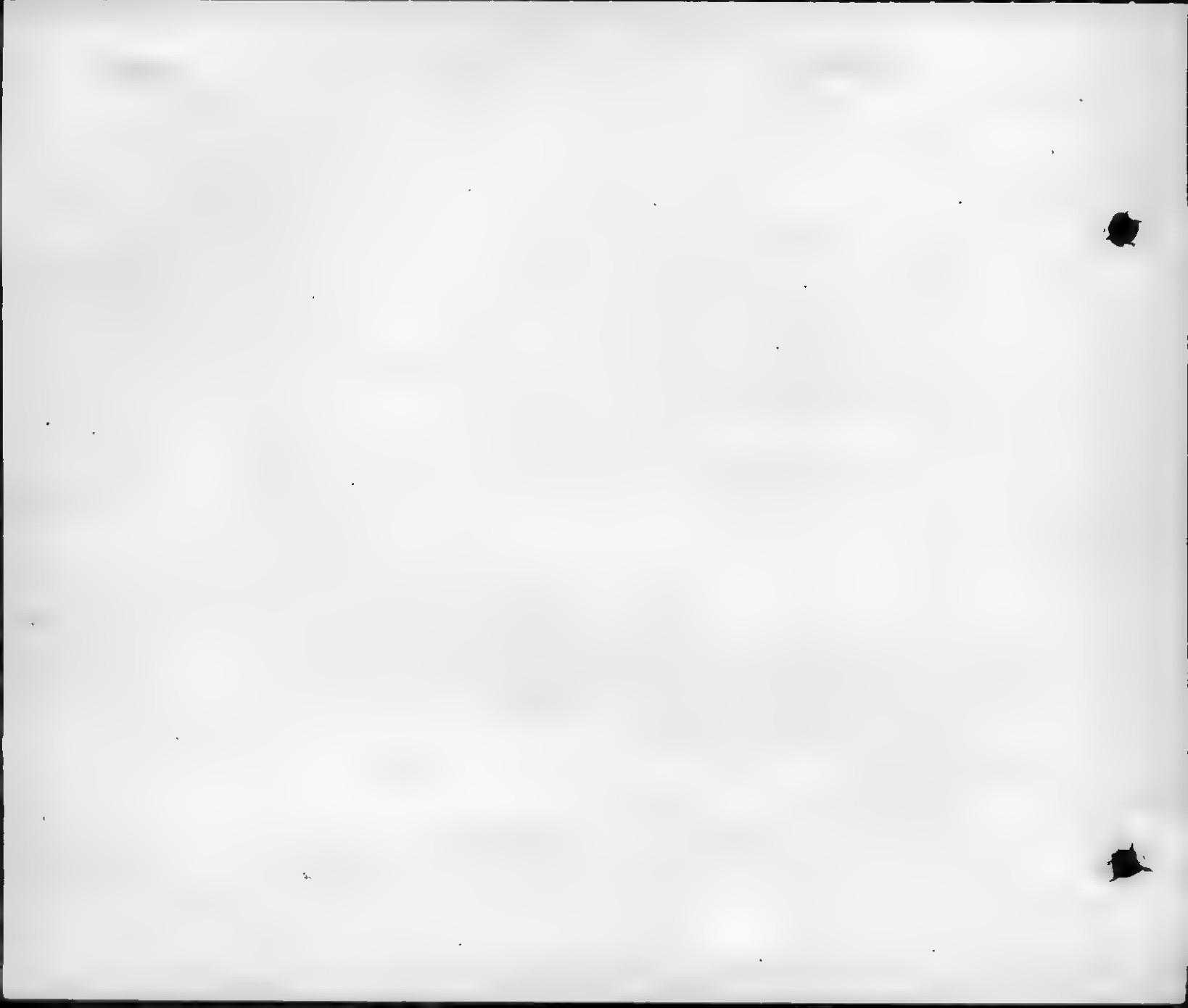
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10186		10182	
1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 26 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) <small>OR INSTITUTION</small> Victor Cullen State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 1814 N. Charles Str.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED <small>(Type or print)</small> Henry		First Middle Clarence	Last Costlow
h. SEX Male		i. COLOR OR RACE White	j. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		k. DATE OF BIRTH 4-3-1902	
		l. AGE (In years <small>at birthday)</small> 59 yrs.	
		m. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min	
n. 10a. USUAL OCCUPATION (Give kind of work done <small>during last 6 months of working life if ever worked)</small> Cook, Painter		10b. KIND OF BUSINESS OR INDUSTRY House Maintenance	
10c. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eben H. Costlow		14. MOTHER'S MAIDEN NAME Laura Hoyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Yes, no, or unknown)</small> No		16. SOCIAL SECURITY NO 177-07-5298	
		17. INFORMANT Record of Victor Cullen Hospital	
		Address Victor Cullen Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN <small>ONSET AND DEATH</small> 8 years	
PART I. DEATH WAS CAUSED BY. <small>IMMEDIATE CAUSE (a)</small> Pulmonary Tuberculosis			
<small>DUE TO</small> Conditions, if any, which <small>gave rise to immediate cause (a), stating the under- lying cause last.</small>		<small>(b)</small> <small>DUE TO</small> <small>(c)</small>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(If either, notify MEDICAL EXAMINER)</small>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 815 (County) 154 (State) 9/28 1961	
21. I certify that (I) (this hospital) attended the deceased from 815 to 154 in 9/28 1961 , that (I) (we) last saw the deceased alive on 9/28 1961 , and that death occurred at 154 from the causes and on the date stated above.			
22a. SIGNATURE Michael G. Zavis		22b. DATE SIGNED 1961	
22c. PHYSICIAN'S NAME (Type) Michael G. Zavis, M.D.		22d. ADDRESS Victor Cullen Hospital, Cullen, Md.	
23a. BURIA., CREMAT. ON, DATE THEREOF <small>REMOVAL (Specify)</small> Burial Oct 2-61		23c. NAME OF CEMETERY OR CREMATORIAL Calvary Cemetery Altoona Pa	
23d. LOCATION (City, town, or county) <small>(State)</small> Altoona Pa			
24. FUNERAL DIRECTOR'S SIGNATURE <small>ADDRESS</small> Raymond & Eugene Thurmont		25a. REC'D BY REGISTRAR <small>DATE OCT 3 '61</small> 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10187

CERTIFICATE OF DEATH

10183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

PLACE OF DEATH

a. COUNTY
Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

LENGTH OF STAY (In 1b)

Since
11/12/60

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

I.O.O.F Home

3. NAME OF
DECEASED
(Type or print)

First Middle

Last

4. DATE
OF
DEATH

Month Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female White

WIDOWED DIVORCED

Nov. 23, 1873

September 24 19 61

9. AGE (in years) IF UNDER 1 YEAR
(last birthday) 87 yrs.

Months Days Hours Min.

13. FATHER'S NAME

William Crabbs

14. MOTHER'S MAIDEN NAME

Annie M. Picking

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give rank or dates of service)

No

214-20-0625

I.O.O.F. Home Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)
DUE TO
(c)

Carcinoma of Right Breast

Metastasis to Lungs

INTERVAL BETWEEN
ONSET AND DEATH

10 months

10 Months

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11/12/60 19 ..., to 9/24/61 19 ..., that (I) (we) last saw the deceased alive on 9/23/61 19 ..., and that death occurred at 12-10 A.M. from the causes and on the date stated above.

22a. SIGNATURE

B.O. Thomas, M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S
NAME (Type)ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

9/24/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 9/27/61

23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM

Mt. Union Cemetery

Frederick, Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

John H. Fuss & Son
C.O. Fuss & Son

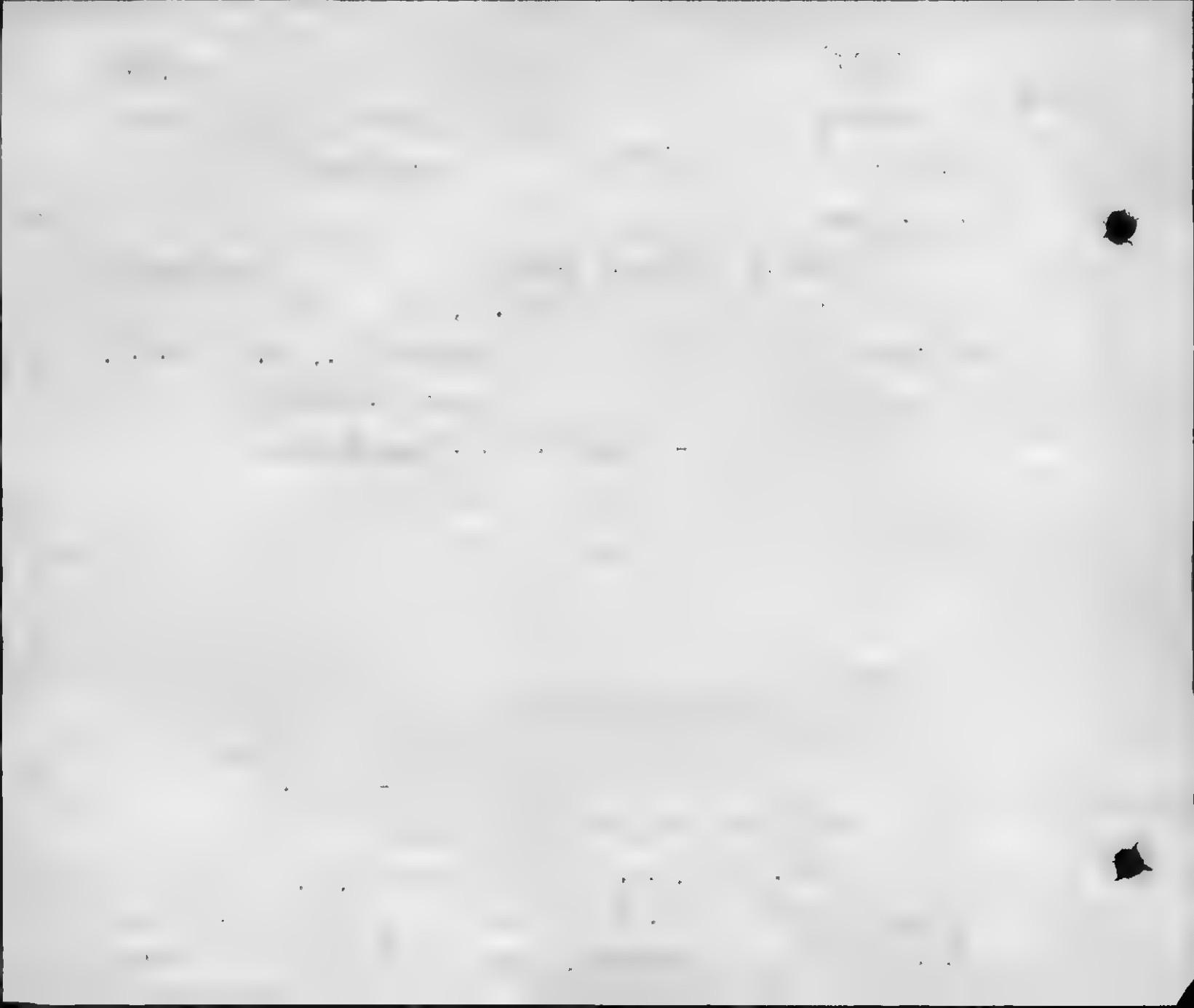
ADDRESS

Toweytown, Maryland

25a. REC'D BY REGISTRAR SEP 27 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10154

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Libertytown</i>		c. LENGTH OF STAY IN 1b <i>Life</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Burial, Libertytown</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MAURICE DANIEL CRUM		First	Middle			
4. DATE OF DEATH <i>Sept. 6 1961</i>		Last	Month			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>Aug. 7 1899</i>		9. AGE (in years from birthday) <i>62 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer - Cattle dealer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own business</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph Crum</i>				
14. MOTHER'S MARRIED NAME <i>Ellen H. Etzler</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16. SOCIAL SECURITY NO <i>217-32-5107</i>		17. INFORMANT <i>Mrs Grace P. Crum, Fred. Rd., Md.</i>	Address <i>[Signature]</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Generalized carcinoma</i> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Carcinoma large bowel</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>8 mos.</i>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>[Signature]</i>	(County) <i>[Signature]</i>	(State) <i>[Signature]</i>
21. I certify that I attended the deceased from <i>Jan. 1961</i> , to <i>Sept. 6 1961</i> , that I last saw the deceased alive on <i>Sept. 6 1961</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>[Signature]</i>		DATE SIGNED <i>Sept. 7 1961</i>		
ACTUAL SIGNATURE <i>Ernest A. Dettbarn</i>		PHYSICIAN'S NAME (Type) <i>ERNEST A. DETTBARN</i>		22d. LOCATION (City, town, or county) <i>M. Libertytown, Md.</i>		
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22f. DATE THEREOF <i>9/9/61</i>	22g. NAME OF CEMETERY OR CREMATORIUM <i>Chapel Cemetery</i>	(State) <i>[Signature]</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>E.C. Barton, Walkersville, Md.</i>		ADDRESS <i>Walkersville, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 11 '61</i>	24b. REGISTRAR'S SIGNATURE <i>John E. Thorne</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurs at home or attending physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 24 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

10189

CERTIFICATE OF DEATH

10185

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

JULIA

KEFAUVER

CULLER

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

December 19, 1888

WIDOWED DIVORCED

9. DATE
OF
DEATH

Month

Day

September

22, 1961

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

At Home

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Richard Kefauver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Maryland

Laura Toms

**21208 East River Read.,
Mrs. Helen C. Fox, Grosse Isle, Mich.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY
(IMMEDIATE CAUSE (a))

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

**Congestive Heart Failure
Atherosclerotic Heart Disease**

INTERVAL BETWEEN
ONSET AND DEATH

3 mo

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Hypertension

20d. ACCIDENT WAS UNDERLYING 20e. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20f. (City or town)
(County) (State)

Hour

a.m.

p.m.

Month, Day, Year

19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from **Sep. 1, 1961** to **Sept. 22, 1961**, that (I) (we) last saw the deceased alive on **Sep. 22, 1961**, and that death occurred at **6:15A** from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

A. A. Pearce, M.D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
9/25/61 SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Sept. 25, 1961

23c. NAME OF CEMETERY OR CREMATORIAL

St. Luke's Cemetery

23d. LOCATION (City, town or county)

(State)

Feagerville,

Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Maryland

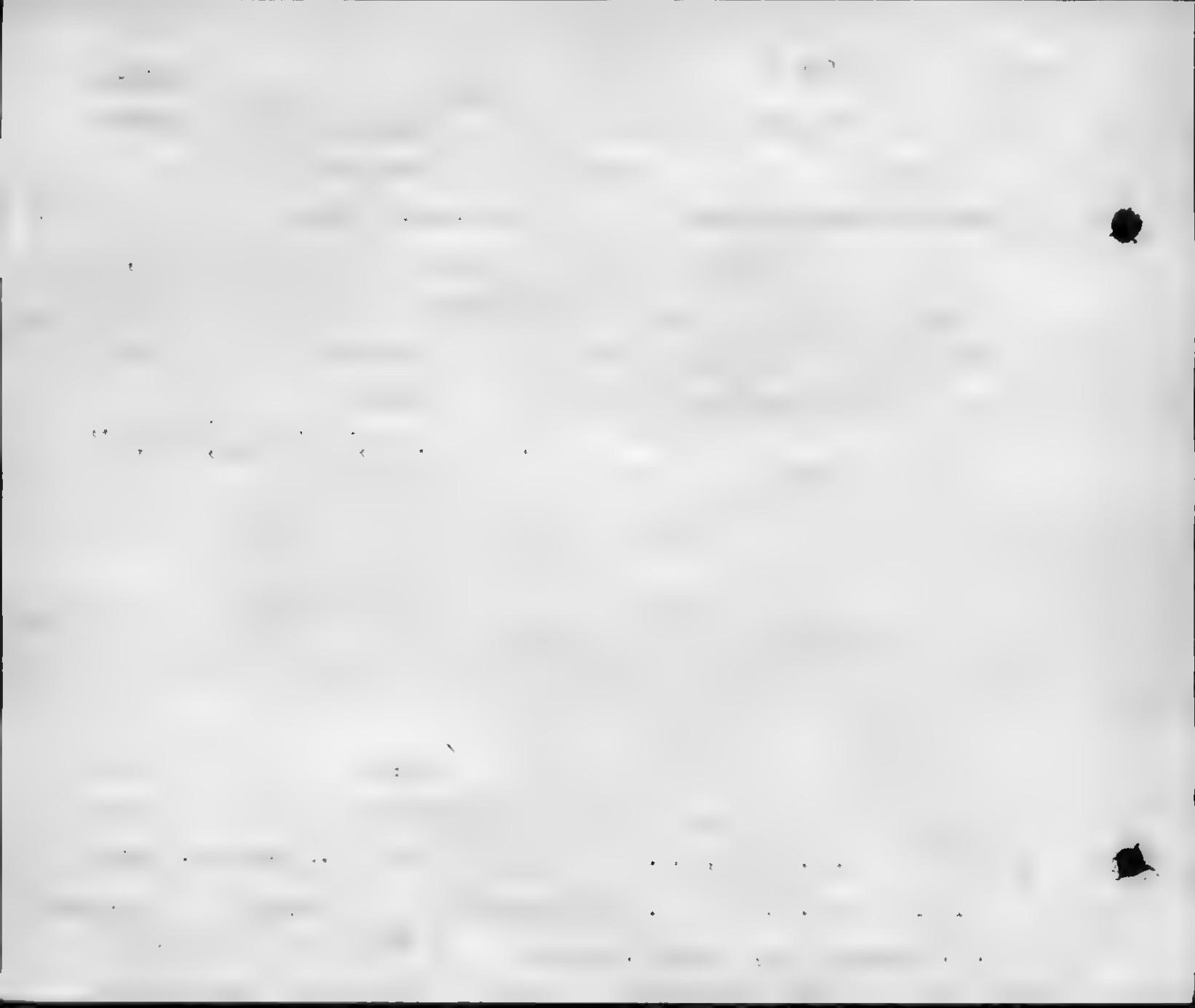
ADDRESS

25e. REC'D BY REGISTRAR

SEP 27 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thrus



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

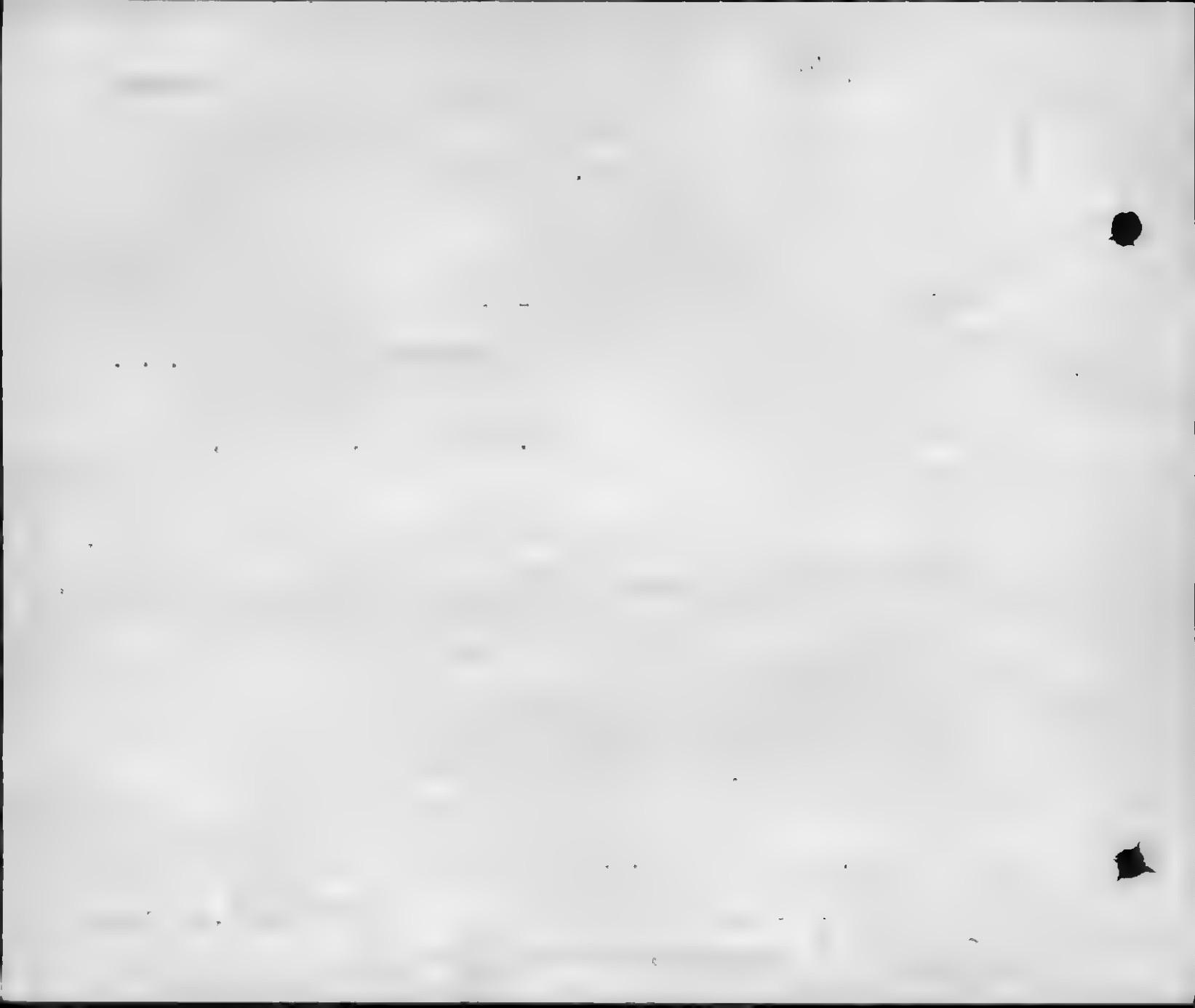
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10190

CERTIFICATE OF DEATH

10186

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institutional, state date of admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb 54 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 301 Maple Avenue		d. STREET ADDRESS 301 Maple Avenue	
3. NAME OF DECEASED (Type or print) Mary Ellen Day		4. DATE OF DEATH Last Month Day Year 9 28 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED		8. DATE OF BIRTH 9-20-1889	
9. AGE (In years at birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0	
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Calvin Grove		14. MOTHER'S MAIDEN NAME Catherine Mankey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or peacetime service) No		16. SOCIAL SECURITY NO 17. INFORMANT Mr. Ernest Day, Brunswick, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first. } (b) DUE TO Congestive Heart Failure } (c) DUE TO Livercirrhosis		INTERVAL BETWEEN ONSET AND DEATH 5 days 1 yr. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ie.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 9, 1958 to Sept. 28, 1961, that (I) (we) last saw the deceased alive on Sept. 28, 1961, and that death occurred at 12:30 A.M. from the causes and on the date stated above.		22a. SIGNATURE  M.D.	
22c. PHYSICIAN'S NAME (Type) C.T. Byron Kao, M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Gum Spring Hollow, Brunswick, Md.	22b. DATE SIGNED Sept. 22, 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-30-1961	23c. NAME OF CEMETERY OR CREMATORIAL Referred	23d. LOCATION (City, town or county) (State) Knoxville, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE  B. G. Field	ADDRESS Brunswick, Maryland	25a. REC'D BY REGISTRAR DAT OCT 2 '61	25b. REGISTRAR'S SIGNATURE Clifford S. Turner



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

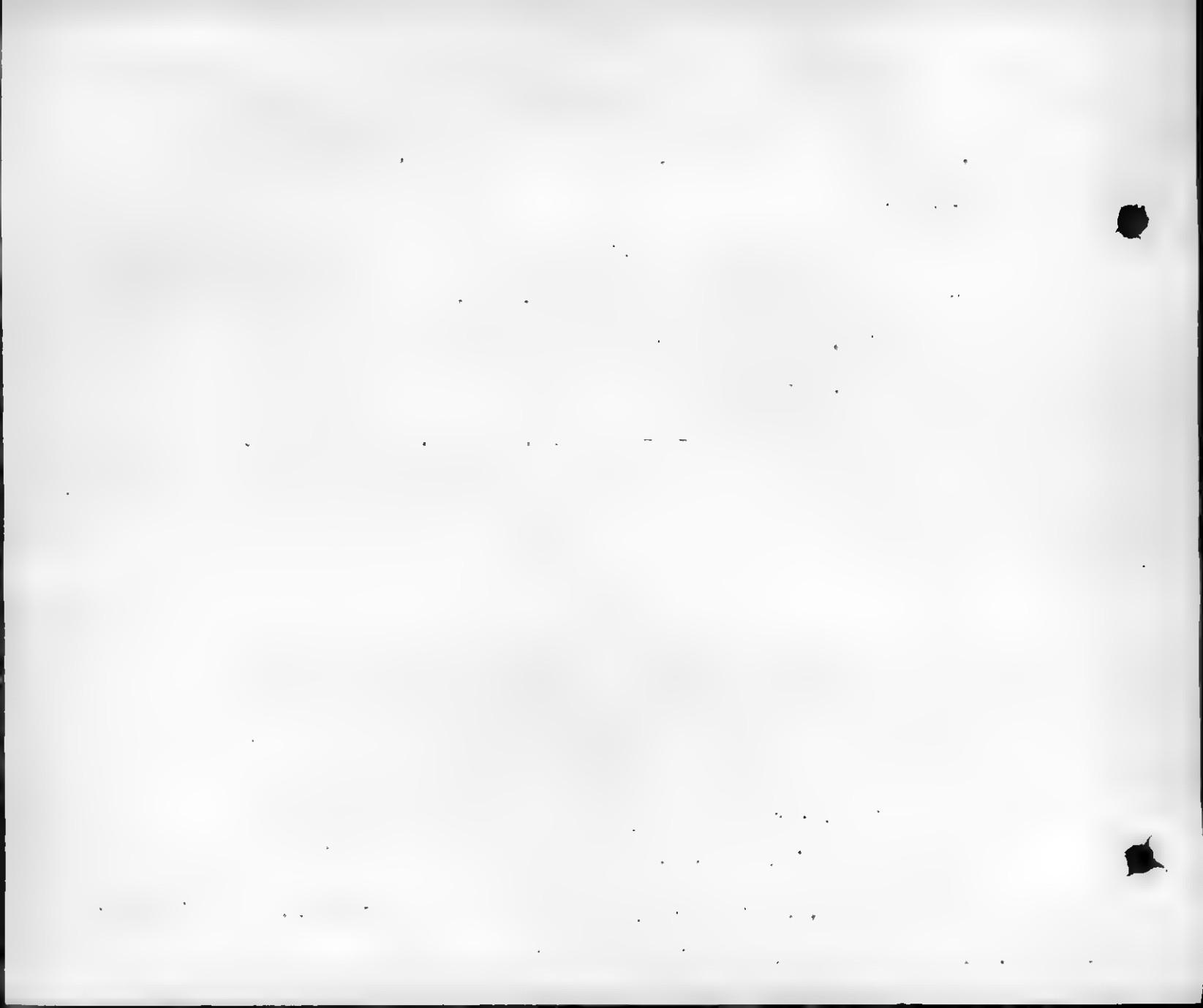
CERTIFICATE OF DEATH

Reg. Dist. No.

10191

1018

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, res. before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN lb Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 Baker Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EDGAR	Middle GILBERT	Last DENNIS
4. DATE OF DEATH	Month September	Day 6	Year 1961
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 16, 1913
9. AGE (In years from birthday) 48	10. KIND OF BUSINESS OR INDUSTRY Salvage Company	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Issac G. Dennis	14. MOTHER'S MAIDEN NAME Jeanette Weddle		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No	16. SOCIAL SECURITY NO. 218-12-6209	INFORMANT Mrs. Alice E. Dennis-Same as Item #2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4 id. / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August , 1951, to September , 1961, that I last saw the deceased alive on September 4 , 1961, and that death occurred at 1:30 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 900 South Main Street DATE SIGNED Sept. 7, 1961			
ACTUAL SIGNATURE W. B. Culwell	M.D.		
PHYSICIAN'S NAME (Type) W. B. Culwell, M. D.			
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 9, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 11 '61	24b. REGISTRAR'S SIGNATURE Walter S. Kraus



1
FOR STATE
HEALTH DEPT.

M

To Designated Agent, Prior to Burial, Cremation, or Removal, in Any Event Within 72 Hours After Death.
TO DIRECTOR: Page 3 Should Be Used As A Burial-Visitation Permit. File Pages 1 and 2 With The State Board of Health.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11364

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Thurmont

c. LENGTH OF STAY IN 16

MARYLAND

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

In Mountains.2 Mi. North of Thurmont

3. NAME OF DECEASED
(Type or print)
First Middle Last

Mearl William Dewees

4. SEX

5. COLOR OR RACE

6. MARRIED NEVER MARRIED 7. DIVORCED

8. DATE OF BIRTH

Male White WIDOWED Jan. 30. 1927

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10f. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Carpenter For Contractors Thurmont.Fredk. Co.Md U.S.A

13. FATHER'S NAME

Morris W. Dewees

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, No, or unknown) If yes, give rank and dates of service)

Yes W.W.2 219-20-3285

16. SOCIAL SECURITY NO.

17. INFORMANT

Lana L.Dewees Thurmont R.D.2 MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

14X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)

DUE TO

(c)

Strangulation By Hanging from tree

Suicide

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITON GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 19

p.m.

20d. INJURY OCCURRED While Not While at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL SIGNATURE B.O.Thomas M.D. ASSISTANT MEDICAL EXAMINER

EXAMINER'S NAME (Type)

B. O. Thomas Professional Bldg

REMEMBER: 22b. DATE THEREOF Oct. 23-1961 Blue Ridge Cem.

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country) Frederick. Md (State)

Burial, Cremation, Removal

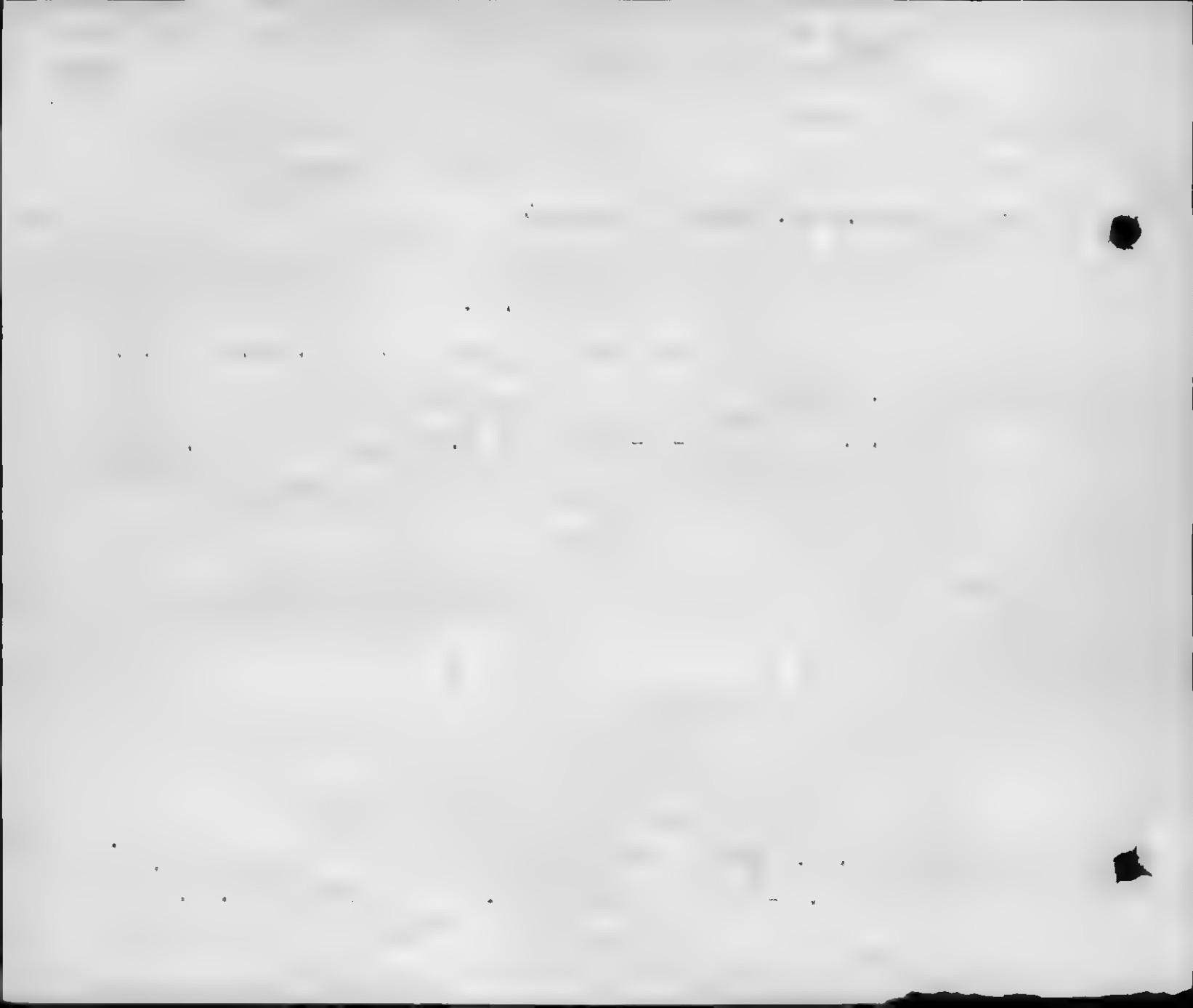
23. FUNERAL DIRECTOR Raymond E. Coagin

ADDRESS Thurmont MD

24e. REC'D BY REGISTRAR OCT 24 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Phane

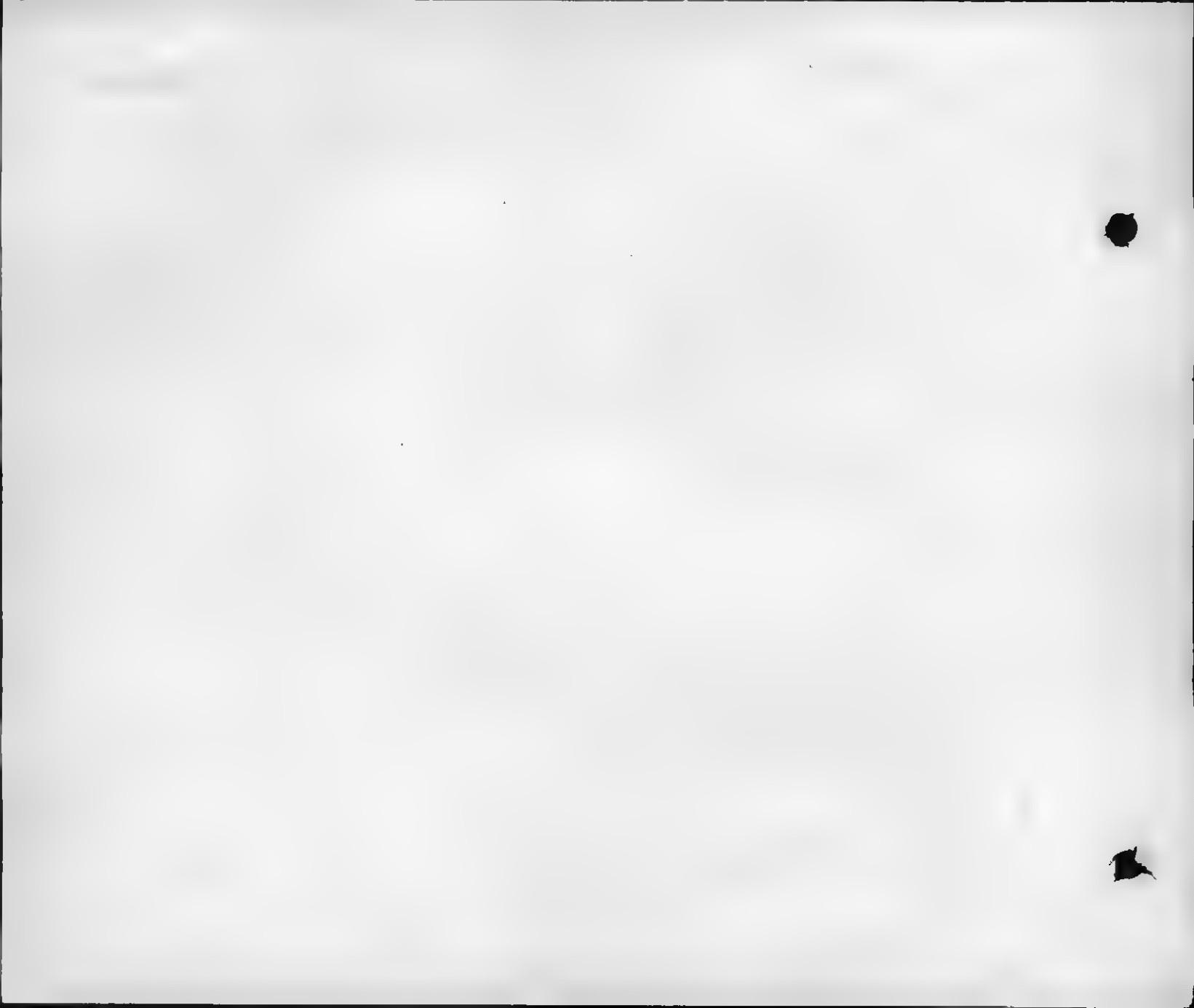
DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10193				10188							
1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN lb 20 years				d. STREET ADDRESS 1412 Columbus Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 418 Institution 418 Columbus Ave.								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lola		First V.		Middle Fink		4. DATE OF DEATH 9 5 1961		Month 9		Day 5	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/27/41		9. AGE (in years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.											
13. FATHER'S NAME Charles W. Beachley				14. MOTHER'S MAIDEN NAME Sarah Alanson				Address 1412 Columbus Ave., Frederick, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none				17. INFORMANT Foster F. Fink, 1412 Columbus Ave., Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 157X Due To Carcinoma Pancreas INTERVAL BETWEEN ONSET AND DEATH 6 months											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 4, 1954 to July 2, 1956 , that (II) (we) last saw the deceased alive on July 5, 1954 , and that death occurred at 3:30 PM , from the causes and on the date stated above											
22a. SIGNATURE Thomas E. Stone				M.D. ATTENDING PHYS <input type="checkbox"/> M.D. MEDECIN <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 9-7-61			
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/8/1961		23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery				23d. LOCATION (City, town, or county) Middletown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				ADDRESS		25a. REC'D BY REGISTRAR SEP 11 '61		25b. REGISTRAR'S SIGNATURE Thomas E. Stone			



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10194

CERTIFICATE OF DEATH

10189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

U.S. 1

M

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Frederick</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Rural Frederick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick Memorial Hosp</i>	
3. NAME OF DECEASED (Type or print)		First <i>Mary</i>	Middle <i>Jane</i>
		Last <i>French</i>	4. DATE OF DEATH Month <i>Sept.</i>
			Day <i>4</i>
			Year <i>1961</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Female</i>		<i>White</i>	8. DATE OF BIRTH <i>Sept. 3, 1961</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) <i>Frederick Md.</i>	
13. FATHER'S NAME <i>James Maxwell French</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Homewood</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <i>MOTHER Mrs Mary French</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Prematurity	
DUE TO <i>776X</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/3 1961</i> , to <i>9/4 1961</i> , that (I) (we) last saw the deceased alive on <i>9/3 1961</i> , and that death occurred at <i>3A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>James B. Thomas</i>		22b. DATE SIGNED <i>9-4-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>James B. Thomas</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. 8U.R.A.L. CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-5-1961</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Mount Olivet Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Frederick Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison and Son, Frederick, Maryland</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>SEP 6 '61</i>
			25b. REGISTRAR'S SIGNATURE <i>C. L. Etchison</i>

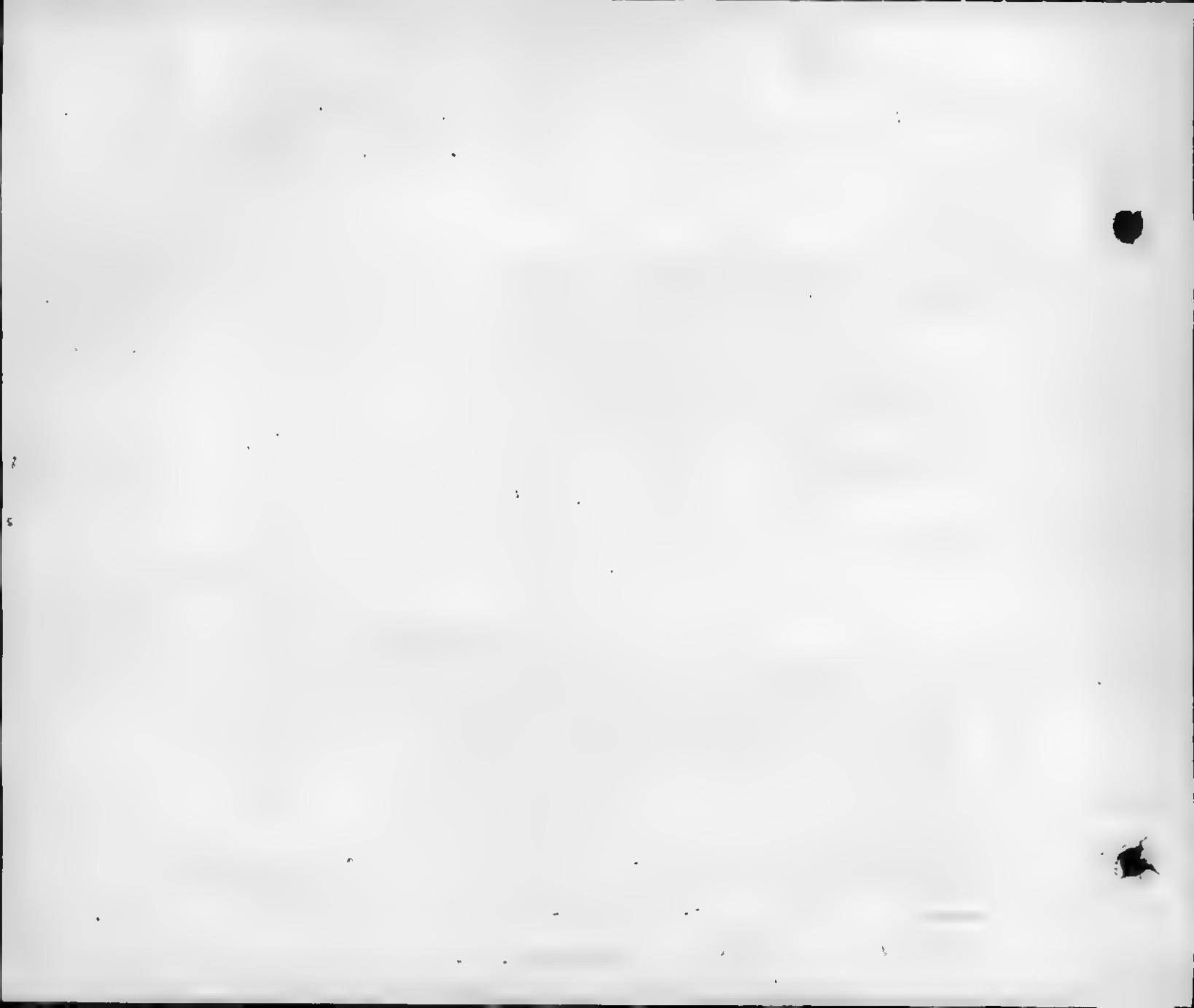
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2069302XVC



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										10190					
10195					CERTIFICATE OF DEATH										
1. PLACE OF DEATH D. COUNTY		FREDERICK			MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) D. STATE		Md.						
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		FREDERICK			c. LENGTH OF STAY IN lb		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Maryland, Thurmont						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		FREDERICK MEMORIAL			d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		Baby 9-1-1			First Middle Last		4. DATE OF DEATH		Month		Day Year				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female W		White				9-22-61		0 yrs		Months Days Hours		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11 BIRTHPLACE (State or foreign country)			12 CITIZEN OF WHAT COUNTRY?						
none						Md.			USA						
13. FATHER'S NAME			FRITZ			14. MOTHER'S MAIDEN NAME			Address						
RONALD						MISNER			Mother Thurmont Md.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			INTERVAL BETWEEN ONSET AND DEATH						
No						Mother									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										DUE TO					
762.5										Anoxia.					
Conditions, if any, which give rise to immediate cause (a), stating the under lying cause last. (b)															
DUE TO (c)										IMMATURITY 24-26w/c 10 Min					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)		(County)		(State)			
19															
21. I certify that (1) (this hospital) attended the deceased from 9/22/61 to 9/22/61, that (1) (we) last saw the deceased alive on 9/22/61, and that death occurred at M, from the causes and on the date stated above										22b. DATE SIGNED 9/22/61					
22a. SIGNATURE HARRY Gray										M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) HARRY W. GRAY										22d. ADDRESS FREDERICK, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 9/25/61			23c. NAME OF CEMETERY OR CREMATORIAL Frederick Memorial Hospital			23d. LOCATION (City, town, or county) Frederick			(State) Md.			
24. FUNERAL-DIRECTOR'S SIGNATURE P. David Youngdale			ADDRESS Frederick, Md.			25a. REC'D BY REGISTRAR OCT 2 '61			25b. REGISTRAR'S SIGNATURE Charles S. Thomas						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M

10196

10191

PLACE OF DEATH

2. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. LENGTH OF STAY IN lb

Since 8/29/61

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Monrovia-Rural R. D. #1

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

d. STREET ADDRESS

Near Kemptown

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

September 12, 1961

Month Day Year

5. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farm Tenant

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

4 July 1893

9. AGE (In years
last birthday)

68 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO

17. INFORMANT

219-20-9764 Mrs. Ruth V. Gaynor (Same as item #2)

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first. } (b)

DUE TO

(c)

Pulmonary embolism
atrial thrombi and myocardial infarction. Unknown
arteriovenous lung disease. UnknownINTERVAL BETWEEN
ONSET AND DEATH

1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e.)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 8/1/61 to 8/12/61, that (I) (we) last saw the deceased alive on 8/12/61, and that death occurred at 1:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Nelson G. Goodman, M. D.

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
15 Sept 1961

22d. ADDRESS

810 Toll House Ave., Frederick, Md.

23e. BURIAL, CREMATION
REMOVAL (Specify)

Burial

9-16-61

23c. NAME OF CEMETERY OR CREMATORIUM

Bethesda Methodist Cem.

23d. LOCATION (City, town or county)

Browningsville, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Md.

ADDRESS

25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE SEP 18 '61

Cathay S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurs in a hospital or attending physician's office, the physician or hospital should file the certificate with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10197

CERTIFICATE OF DEATH

10192

1. PLACE OF DEATH
 a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

FRANK

LORENZO

GOODMAN

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

July 13, 1883

9. DATE OF
DEATH

September 7, 1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Mail Carrier

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Mail

11. BIRTHPLACE (County & State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George T. Goodman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Mrs. Hilda G. Dudash, Same as Item #2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a)

502.0

DUE TO

Conditions, if any, which
 gave rise to immediate cause
 (a), stating the underlying
 cause last.

(b)

DUE TO

(c)

Arteriosclerosis, generalized
chronic bronchitis + pulmonary emphysema 5-10 yrs.

INTERVAL BETWEEN
 ONSET AND DEATH

1 year

MEDICAL CERTIFICATION

20e. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
 Hour e.m.
 p.m.

20d. INJURY OCCURRED
 While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from... 2-1-1958 to... 9-7-1961, that (I) (we) last saw the deceased alive on... 8-31-1961, and that death occurred 1:10P.M. from the causes and on the date stated above.

22e. SIGNATURE

Rex R. Martin

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
 9/8/61

22e. PHYSICIAN'S NAME (Type)

Rex R. Martin, M.D.

22d. ADDRESS

North Market St., Frederick, Md.

23e. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial

Sept. 11, 1961

Mount Olivet Cemetery

Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

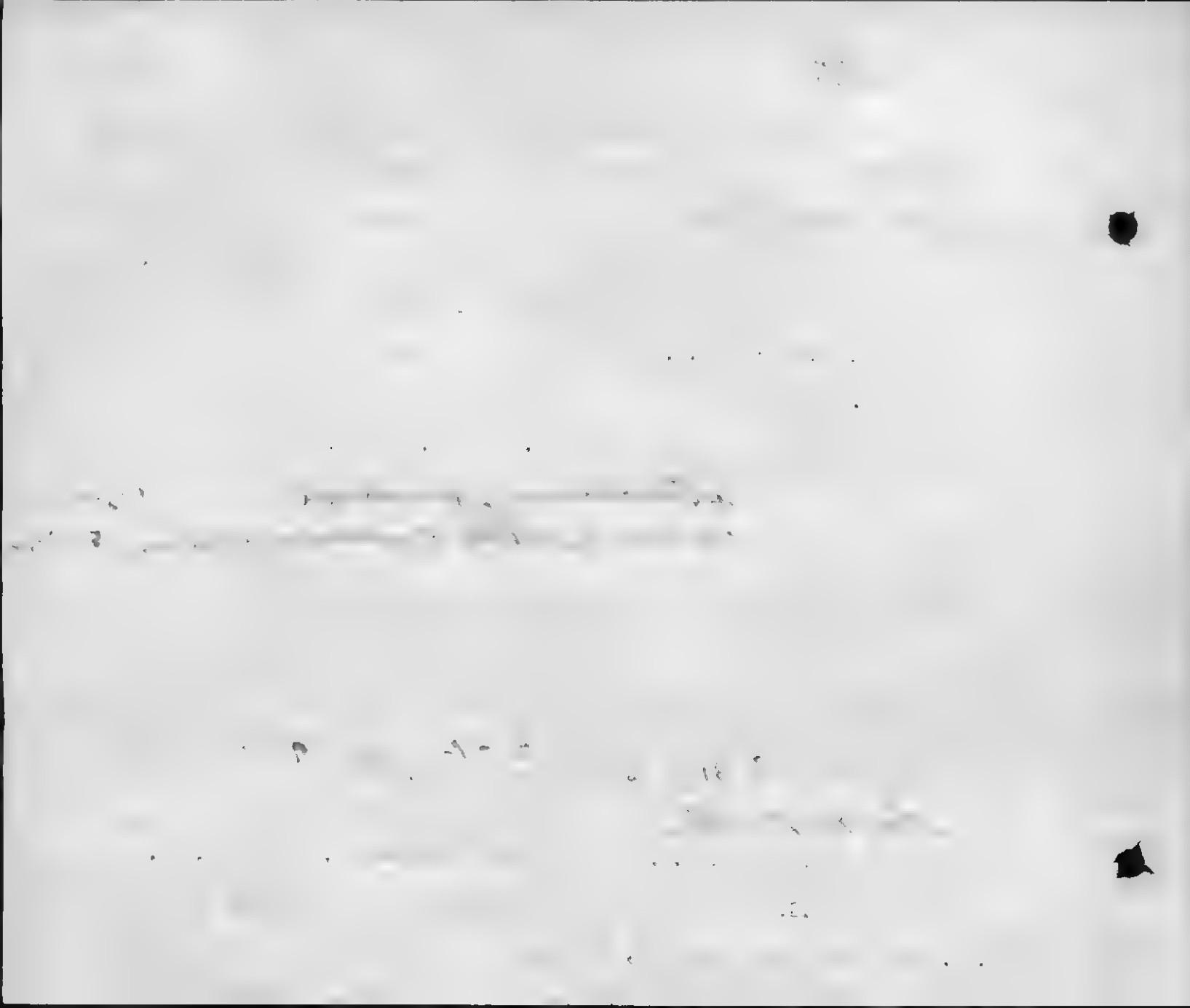
M. R. Etchison & Son, Frederick, Maryland

25a. REG'D BY REGISTRAR

SEP 11 '61
 DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause



12
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10198 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10193

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Lederal Center

First

Middle

Alwis

3. NAME OF
DECEASED
(Type or print)

Earl

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

10-12-1906

9. AGE (In years
at time of death)

54

IF UNDER 1 YEAR
Months Days Hours Min

e. IS RESIDENCE
ON A FARM?
YES NO

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Brakeman B.&O.R.R.Co (Railroad)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

John C. Grove

14. MOTHER'S MAIDEN NAME

Bertha Shivers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war or dates of service)

World War II

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Loretta Grove, Brunswick, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

B.O.Thomas

EXAMINER'S
NAME (Type)

B.O.Thomas, Frederick, Md

CHIEF MEDICAL EXAMINER

M.D. ASS STANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

9/11/1961

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

9-15-1961

22c. NAME OF CEMETERY OR CREMATORIAL

Reformed

22d. LOCATION (City, town, or county)

(State)

Knoxville, Maryland

23. FUNERAL DIRECTOR

B. Lee Zelt

ADDRESS

Brunswick, Maryland

24a. REC'D BY REGISTRAR

DATE SEP 13 '61

24b. REGISTRAR'S SIGNATURE



FOR STATE
HEALTH DEPT.

TO DEFENDANT IN CRIMINAL EXAMINEE This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 22 Film 6294 9/11/61

1. PLACE OF DEATH
a. COUNTY

M

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick-Rural-R.D.#2

c. LENGTH OF STAY IN 1b

Hour

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1.2 Mile-South Frederick-Md.#355

3. NAME OF
DECEASED
(Type or print)

First

Middle

ROBERT

LEE

HAMILTON

4. SEX

6. COLOR OR RACE

Male

White

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

March 11, 1940

13. FATHER'S NAME

R.

Carl R. Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

217-36-4364 Mr. Carl R. Hamilton-Same as Item #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a).

981 X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Punctured Aorta -Due To Bullet Wound

INTERVAL BETWEEN
ONSET AND DEATH
Instant

MEDICAL CERTIFICATION

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year
Hours a.m. 12:15 ** Sept. 4, 1961

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED While Not White at work at work Tavern

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) **Nr. Frederick, Fred. Co., Md.**

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

B. O. Thomas

CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type)
REMOVAL (Specify)

B. O. Thomas, M.D.

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

22e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF Sept. 7, 1961

22c. NAME OF CEMETERY OR CREMATORIAL Union Chapel Cemetery

22d. LOCATION (City, town, or country) **Frederick County, Maryland**

Address (Street, city, town, or county)
9/4/61

(State)

23. FUNERAL DIRECTOR

ADDRESS

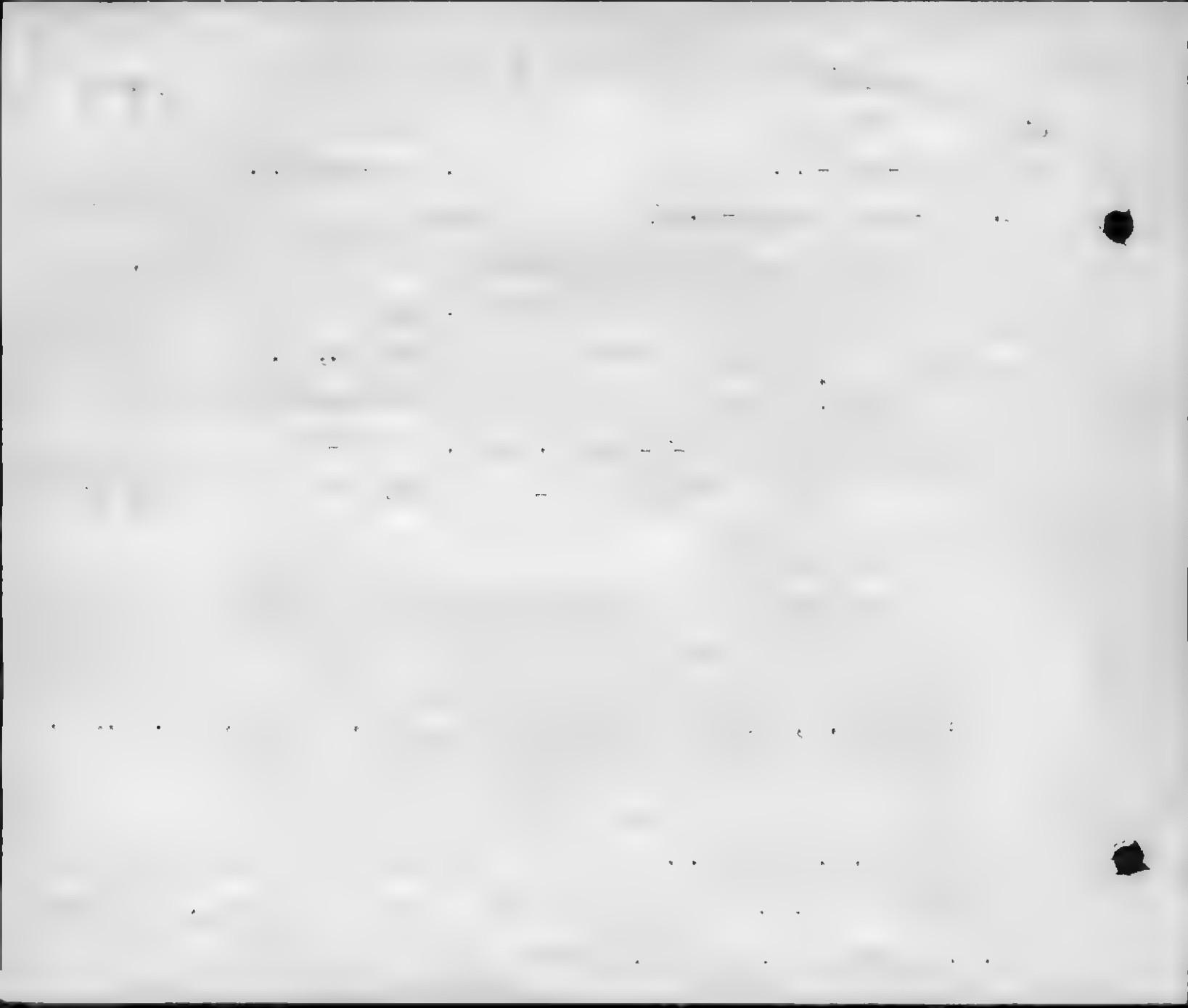
M. R. Etchison & Son, Frederick, Maryland

24e. REC'D BY REGISTRAR

DATE SEP 6 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline



HOSPITAL **ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10200

CERTIFICATE OF DEATH

10195

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick-Rural-R.D.#1

c. LENGTH OF STAY IN lb

MARYLAND

Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Mt. Pleasant

3. NAME OF
DECEASED
(Type or print)

First
CHARLES

Middle
EDWARD

HOFFMAN

Mt. Pleasant

Last

4. DATE
OF
DEATH

Month
September
Day
3, 19 61

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

B. DATE OF BIRTH

July 24, 1904

9. AGE (In years
last birthday) IF UNDER 1 YEAR
57 yrs Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Garage-Owner

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or lone gr country)

Same

Frederick County, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles W. Hoffman

Dessie M. Fox

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give rank or date of service)

No

217-32-5060 Mrs. Beulah M. Hoffman-Same as Item #1

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Carcinoma Colon

INTERVAL BETWEEN
ONSET AND DEATH

1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11-28, 1960 to 9-3, 1961, that (I) (we) last saw the deceased alive on 9-3, 1961, and that death occurred at 7:PM, from the causes and on the date stated above.

22a. SIGNATURE

T. E. Stone, M.D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR STAFF
PHYS.

22b. DATE
SIGNED
9/5/61

22c. PHYSICIAN'S
NAME (Type)

T. E. Stone, M.D.

22d. ADDRESS

W. Third Street, Frederick, Maryland

23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

Burial

Sept. 6, 1961

23c. NAME OF CEMETERY OR CREMATORIUM

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick,

(State)

Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Maryland

ADDRESS

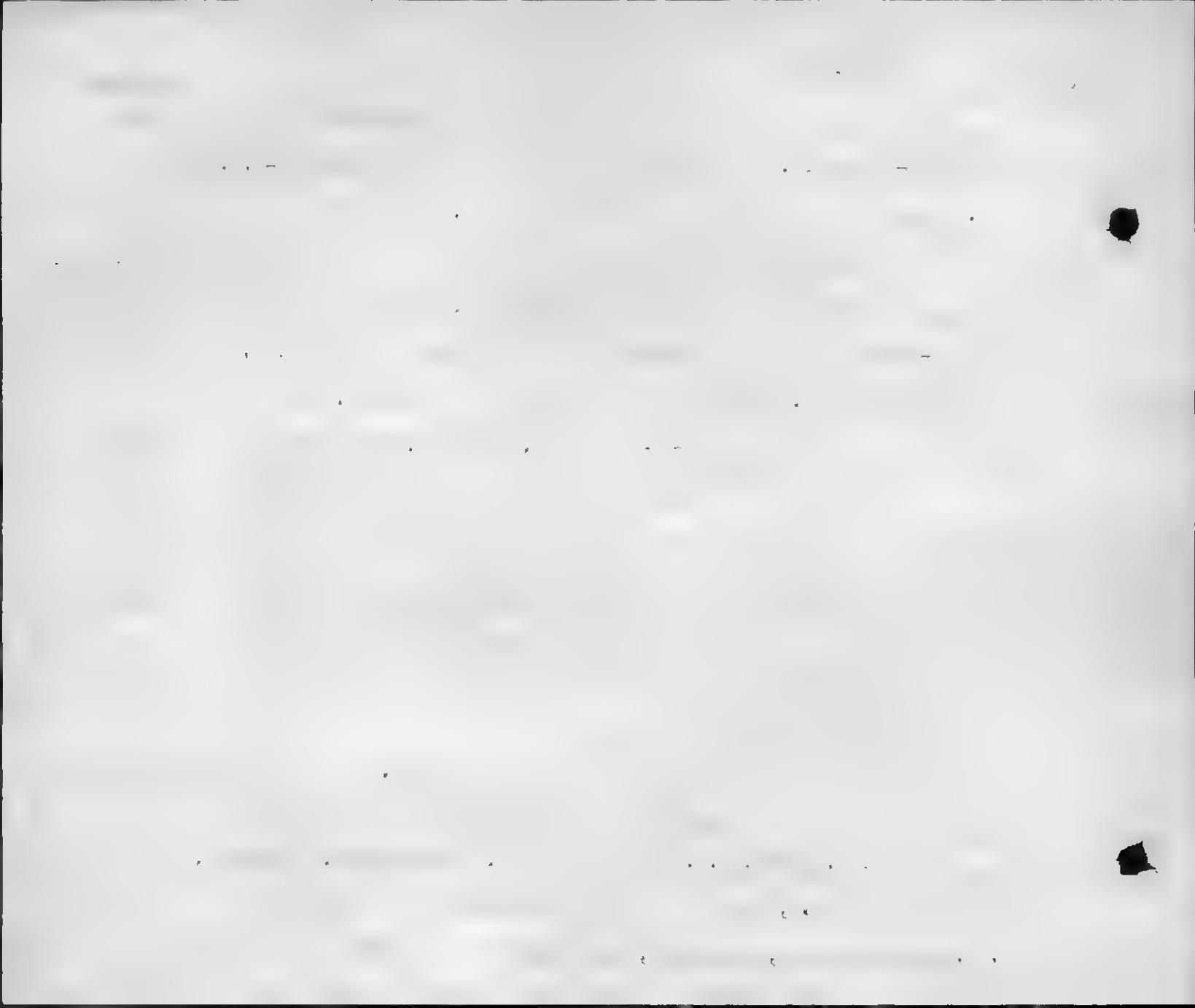
25a. REC'D BY REGISTRAR

SEP 8 '61

25b. REGISTRAR'S SIGNATURE

DATE

Arthur S. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Page 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10201

10196

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville		c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
RHODA ELEANOR				Houck	Sept.	23	1961	
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
F	W				August 16 1897	74		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		10c. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel M. Strine		14. MOTHER'S MARRIED NAME Laura Albaugh						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. Elmer J. Houck, Walkersville, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH 2 hours		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		Anterior Myocardial Infarction				several years		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
19								
21. I certify that (I) (this hospital) attended the deceased from July 1961 to Sept. 23, 1961 , that (I) (we) last saw the deceased alive on Sept. 22, 1961 , and that death occurred at 4:30 PM , from the causes and on the date stated above.								
22a. SIGNATURE Ernest A. Dettbarn		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Sept. 25/61				
22c. PHYSICIAN'S NAME (Type) ERNEST A. DETTBARN		22d. ADDRESS Walkersville, Md.						
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/26/61		23c. NAME OF CEMETERY OR CREMATORIAL Glade Cemetery		23d. LOCATION (City, town, or county) Walkersville		(State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE J.C. Barton		ADDRESS Walkersville, Md.		25a. REC'D BY REGISTRAR DATE SEP 26 '61		25b. REGISTRAR'S SIGNATURE John S. Knue		



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10197

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please seal the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
e. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Thurmont R.F.D.2

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle Last

Goldie Marie Hurley

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

January 28, 1919

13. FATHER'S NAME

Elmer Hurley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

No

16. SOCIAL SECURITY NO. I 17. INFORMANT

214-34-0308 Leroy Toms, Thurmont R.F.D.2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last

DUE TO

(b)

DUE TO

(c)

Acute Congestive Heart Failure
Hypertensive Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH
hrs.

Yrs.

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

B.O. Thomas

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

B.O. Thomas, M.D.

DEPUTY MEDICAL EXAMINER

September 19, 1961

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

22e. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

9-19-61

22c. NAME OF CEMETERY OR CREMATORIUM

Mt. Bethel Cem.

22d. LOCATION (City, town, or country)

Garfield Frea. Co. Md.

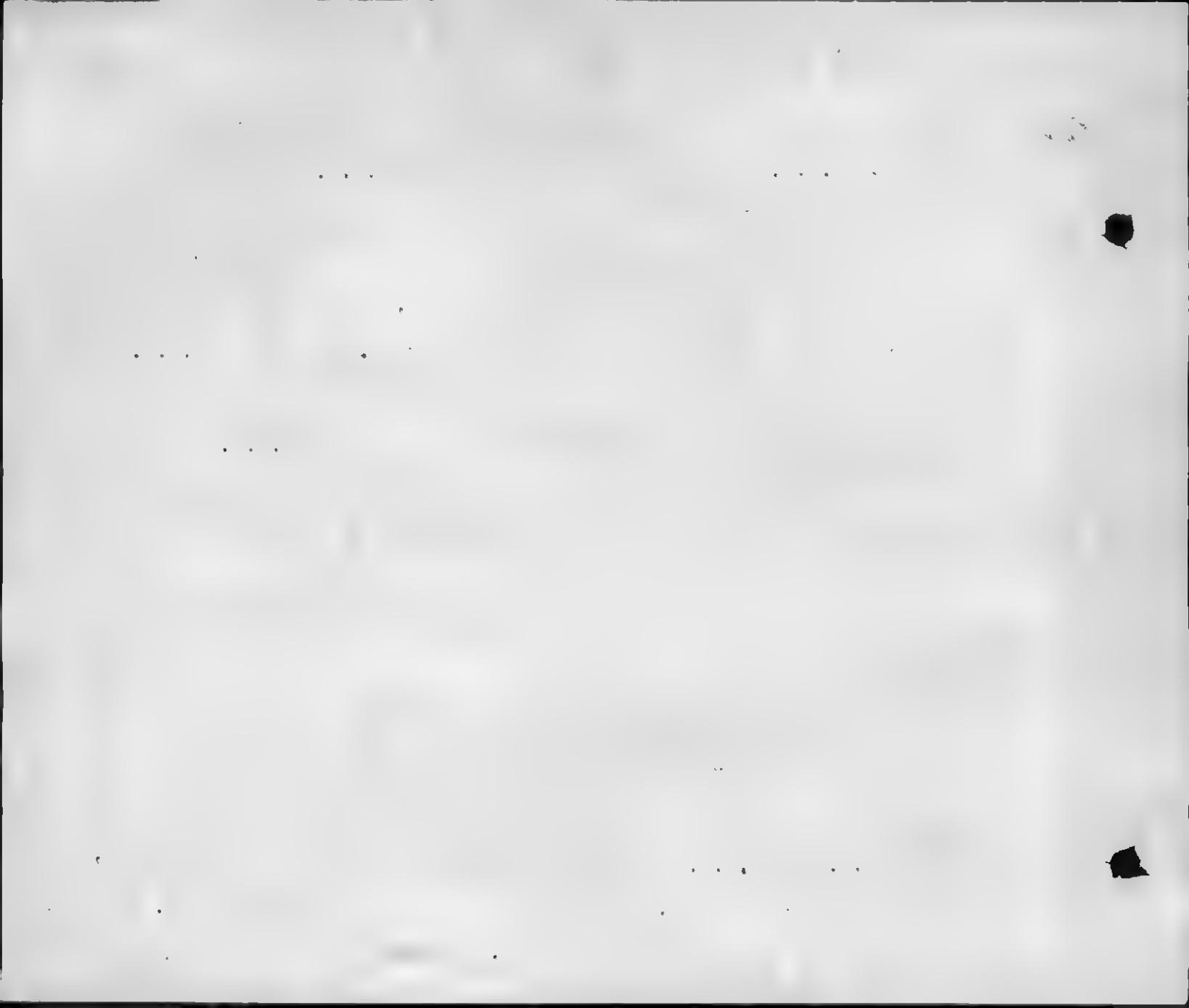
23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

DATE 20 '61

24b. REGISTRAR'S SIGNATURE



1
FOR STATE
HEALTH DEPT
M

TO DEATH
Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10203 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10198

1. PLACE OF DEATH e. COUNTY	Frederick		c. LENGTH OF STAY IN 1b	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Montgomery		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Frederick Memorial Hosp		d. STREET ADDRESS	Mt. airy Rd. 3		
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH	Month	Day	
5. SEX	W	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	Sept. 1	
	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 9, 1941	1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		
13. FATHER'S NAME	George M. Kelly		14. MOTHER'S MAIDEN NAME	Washington D.C. U.S.A		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give rank and dates of service]	No		16. SOCIAL SECURITY NO	17. INFORMANT		
			218-38-3205	George M. Kelly, Mt. airy Rd. 3		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	Fracture Base of Skull		INTERVAL BETWEEN ONSET AND DEATH		1/2 hour	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)					
	DUE TO					
	(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m.	Auto ran into trailer tractor		White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	(City or town) Route 40 Frederick, Maryland		
12:30 pm 9/1/61				(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL <u>B. O. Thomas</u>						
EXAMINER'S NAME (Type)	<u>B. O. Thomas</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/1/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Burial	9/5/61	Gate of Heaven	Address (Street, city, town, or county)			
23. FUNERAL DIRECTOR	ADDRESS	Damascus, Md.	24d. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Olin L. Mohsanth					Arthur S. Krause	
VS. A15ME 5M 7/59						
SEP 6 '61						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurs after 4 PM, it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10204

CERTIFICATE OF DEATH

10199

1. PLACE OF DEATH
e. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb
Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

FREDERICK

First

Middle

JOHN

KOTTMAYER

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

April 16, 1881

Last

4

DATE
OF
DEATH

September

5,

19 61

Month

Day

Year

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Molder

10b. KIND OF BUSINESS OR INDUSTRY

Iron & Steel Co.

11. BIRTHPLACE (County & State, or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry John Kottmyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or grade of service)

No

16. SOCIAL SECURITY NO.

214-10-3400

17. INFORMANT

Mrs. Mildred L. Kottmyer-Same as Item #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause (b).
DUE TO
(c)

Cerebral Hemorrhage.
Arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

12 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY
Hour e.m.
p.m.

20b. INJURY OCCURRED
While at work Not While at work

20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20d. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 24, 1961 to Sept. 5, 1961, that (I) (we) last saw the deceased alive on Sept. 5, 1961, and that death occurred 2:30P.M. from the causes and on the date stated above.

22a. SIGNATURE

A. A. Pearce

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

9/8/1961

22c. PHYSICIAN'S
NAME (Type)

A. A. Pearce, M. D.

22d. ADDRESS

East Church Street, Frederick, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial Sept. 9, 1961

23c. NAME OF CEMETERY OR CREMATORIUM

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick,

(State)

Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Maryland

ADDRESS

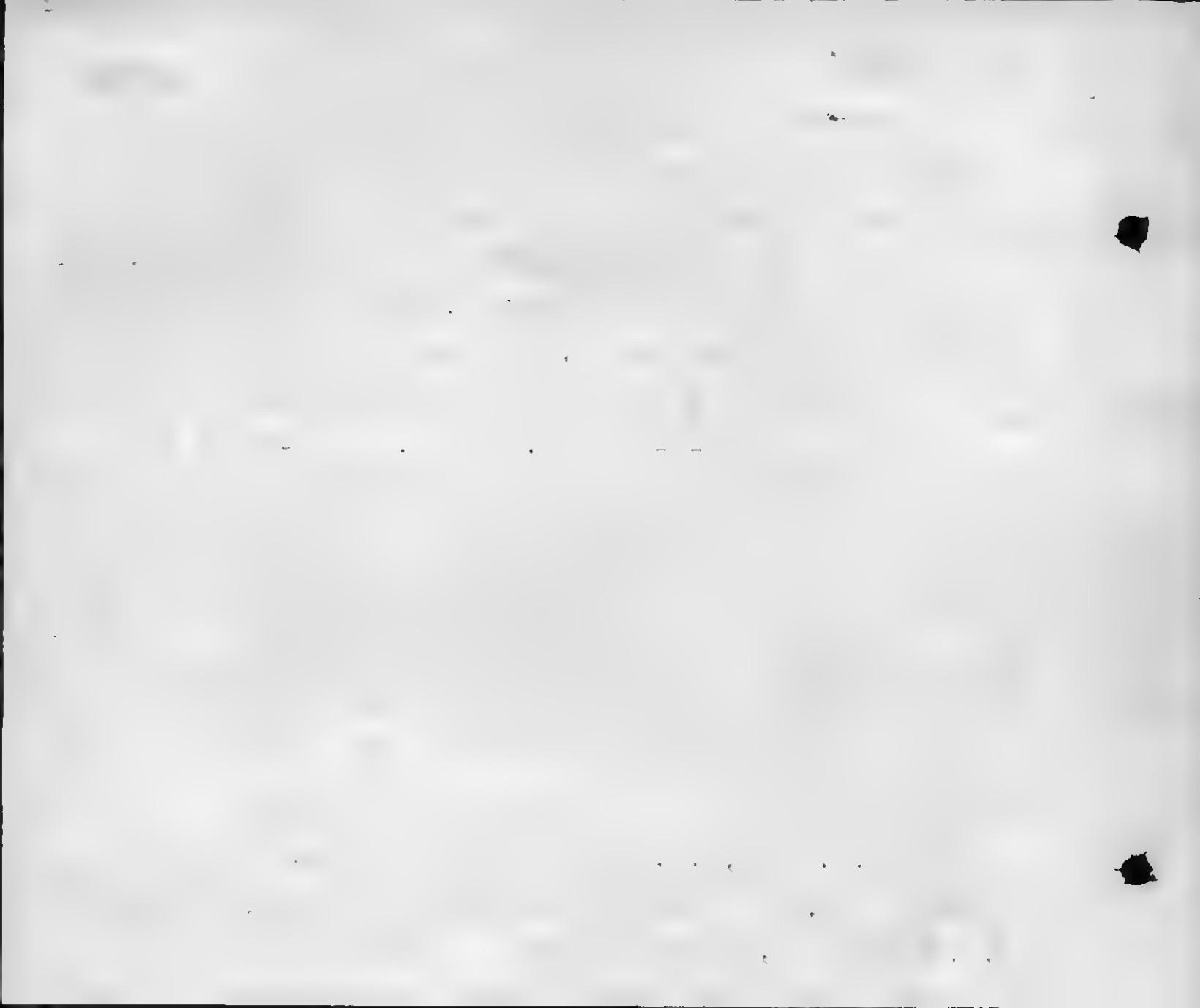
25a. REC'D BY REGISTRAR

SEP 11 1961

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Pearce



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

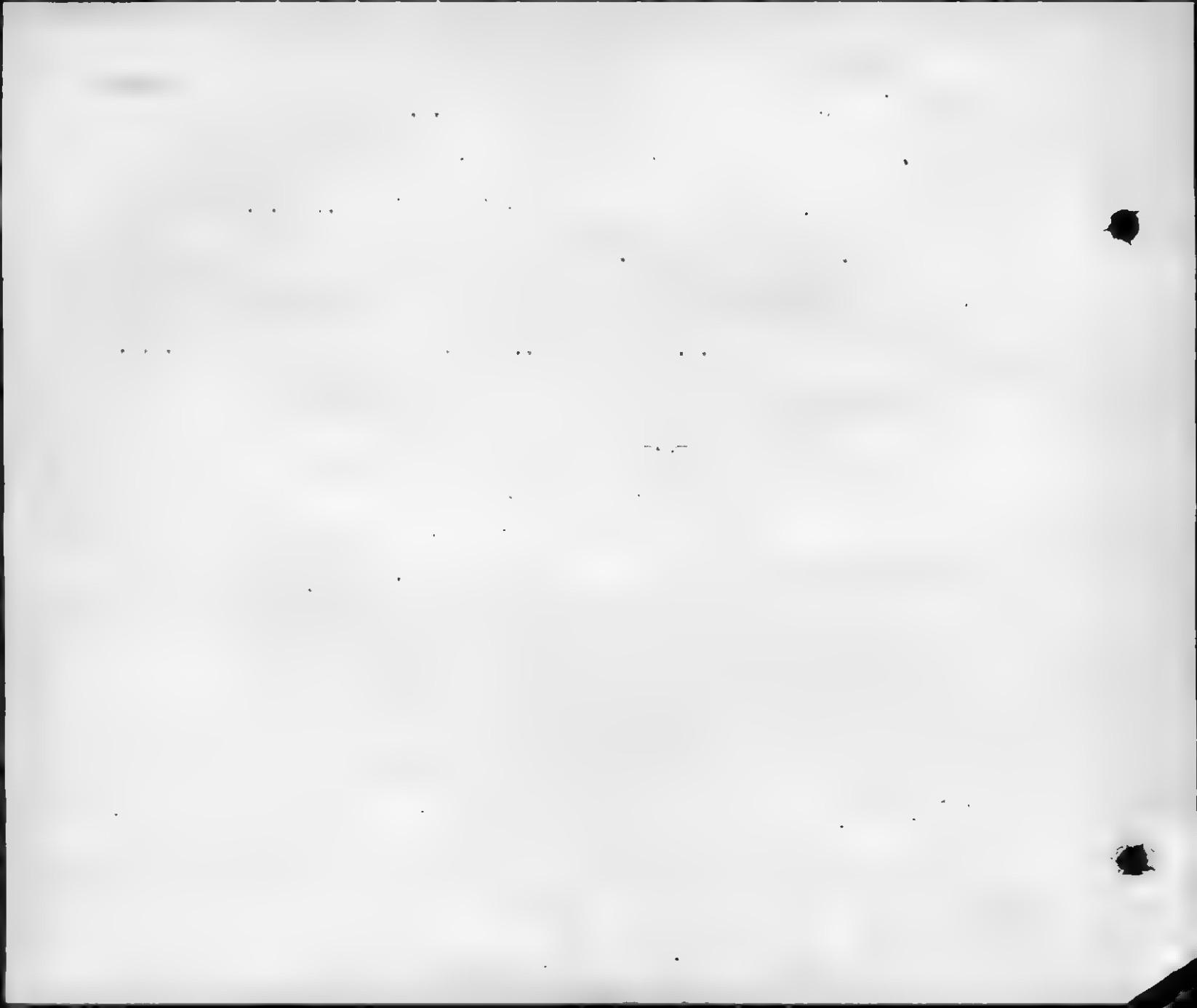
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10205

10200

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence b. below)		b. STATE N.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenville</i>		d. STREET ADDRESS <i>402 East 8th St., P.O. Box 681</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mr. David</i>	Middle <i>LEROY</i>	Last <i>Latham</i>	4. DATE OF DEATH	Month 9	Day 26	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3/13/94</i>	9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months 67	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNKNOWN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>M.J. Grove Lime Co.</i>		11. BIRTHPLACE (State or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>UNKNOWN</i>			14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-03-6473</i>		17. INFORMANT <i>Unknown</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: <small>IMMEDIATE CAUSE (a)</small> <i>Cerebral Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH 24 hrs <small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last</small> <small>(b)</small> <i>Benign Prostatic Hypertrophy</i> 10 yrs <small>DUE TO</small> <small>(c)</small> <i>Bladder diverticulum; Uremia</i> "							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<i>the hospital</i>) attended the deceased from <i>9-18-1961</i> to <i>9-26-1961</i> , that (I) (<i>not</i>) last saw the deceased alive on <i>9-26-1961</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert D. Crouch</i>				M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>ROBERT D. Crouch</i>				22b. DATE SIGNED 9-26-61			
23a. BURIAL, CREMATION REMOVAL, (Specify) <i>Removal</i>		23b. DATE THEREOF <i>4/26/61</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town, or county) <i>WASHINGTON, N.C.</i> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison Son Frederick MD</i>				25a. REC'D BY REGISTRAR DATE <i>SEP 29 '61</i>		25b. REGISTRAR'S SIGNATURE <i>C. E. Knue</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 days may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

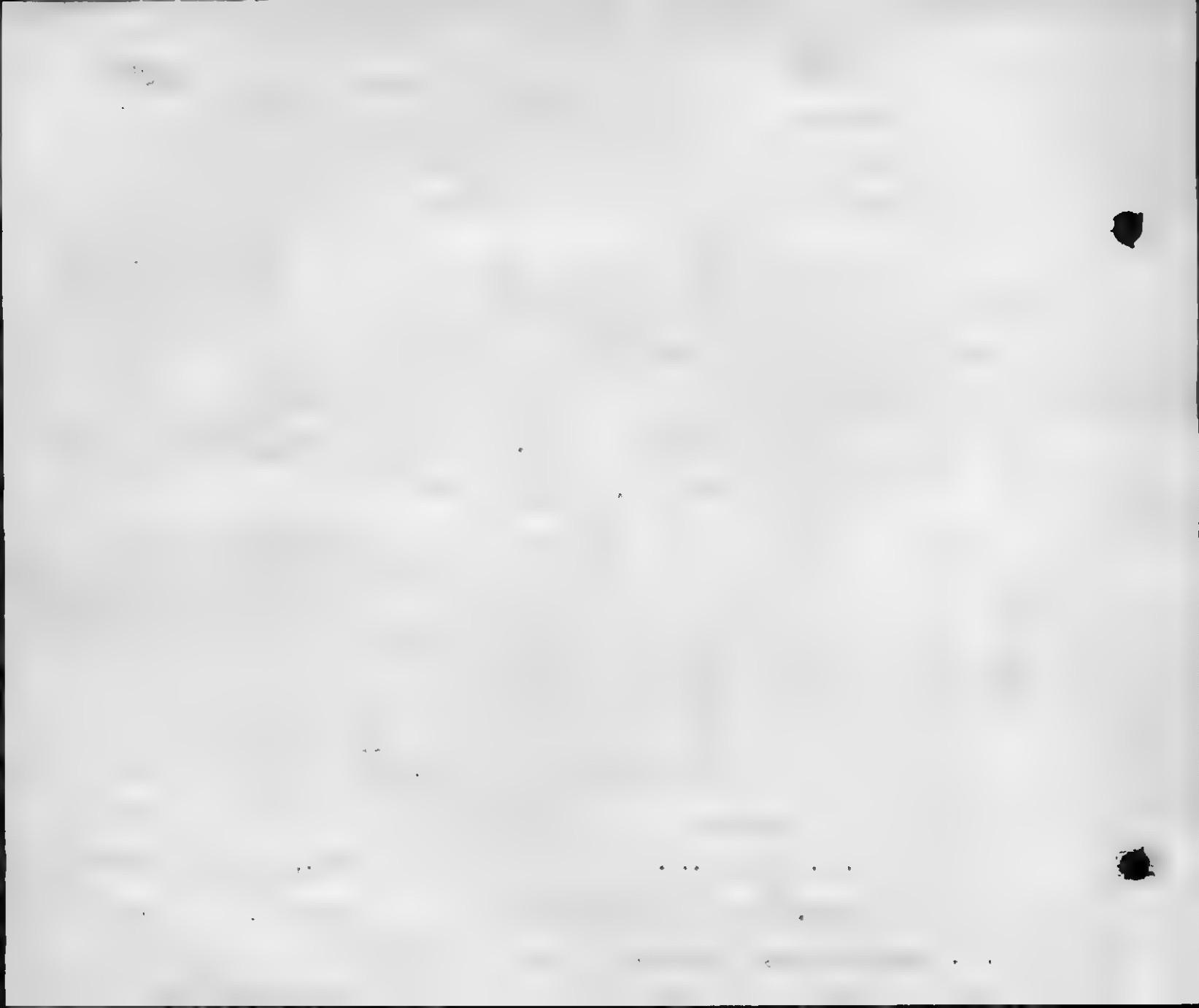
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10206

CERTIFICATE OF DEATH

10201

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN b. Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		11. STREET ADDRESS 28 East Third Street	
3. NAME OF DECEASED (Type or print)	First GRACE	Middle WORMAN	Last LEBHERZ
4. DATE OF DEATH September 7, 1961	Month Sept	Day 7	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
10c. FATHER'S NAME Charles Worman		11. BIRTHPLACE (County & State, or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT None Mrs. Margaret L. Worster, Frederick, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199X Conditions, if any, which give rise to immediate cause (b) (a), stating the underlying cause last. (c)		DUE TO Carcinoma tonsi	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 20g. (County) 20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 1961 to 9/7/61, that (I) (we) last saw the deceased alive on 9/6/1961, and that death occurred at 3:35A.M., from the causes and on the date stated above.			
22e. SIGNATURE J. B. Thomas,			
22c. PHYSICIAN'S NAME (Type) J. B. Thomas, M.D.	M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/8/61
22d. ADDRESS Professional Bldg., Frederick, Maryland			
23a. BURIAL, Cremation, Removal (Specify) Burial	23b. DATE THEREOF Sept. 9, 1961	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	23d. LOCATION (City, town or county) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE SEP 11 '61	
		25b. REGISTRAR'S SIGNATURE Caroline E. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10207

CERTIFICATE OF DEATH

10202

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and the nearest town)

Rural Smithsburg

c. LENGTH OF STAY IN lb

II yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Own Home

3. NAME OF
DECEASED
(Type or print)

ANN First

MIDDLE MAY

LINTON

4. DATE
OF
DEATH

WIDOWED

DIVORCED

Last

Month

Sept.

1961 19

Dey

Year

5. SEX

Female White

NEVER MARRIED

B. DATE OF BIRTH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Hours

Days

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (County & State, or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Columbus Tracey

14. MOTHER'S MAIDEN NAME

Mary Manahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? [Yes, no, or unknown] (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Donald Toms

Address

Thurmont. R.D. MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CORONARY THROMBOSIS

INTERVAL BETWEEN
ONSET AND DEATH

2 hr

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b) DUE TO
} (c) DUE TOARTERIOSCLEROTIC HEART DISEASE
GENERALIZED ARTERIOSCLEROSIS

15 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

HYPERTENSIVE HEART DISEASE

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
White Not White
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 31, 1961, to Sept. 27, 1961, that (I) (we) last
saw the deceased alive on Sept. 27, 1961, and that death occurred at 8:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE

E. R. Lardizabel

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
27.8.61

23a. BURIAL, CREMATION, REMOVAL

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial Sept. 30/1961 At. Bethel Methodist Cem. Garfield Fredk. Co. Md

24. FUNERAL DIRECTOR'S SIGNATURE

Raymond E. Greager

ADDRESS

Thurmont MD

25a. REC'D BY REGISTRAR

DATE OCT 3 '61

25b. REGISTRAR'S SIGNATURE

Cathleen S. Thomas

$T_1 \rightarrow T_2$

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10208

CERTIFICATE OF DEATH

10203

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

2 Months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First EILEEN Middle

ETHEL / SHANK

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Pressing

10b. KIND OF BUSINESS OR INDUSTRY

Laundry

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter K. Shank

14. MOTHER'S MAIDEN NAME

Evelyn M. Collins

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

214-628-5823 Mr. Glen L. Linton-Same as Item #2

18. CAUSE OF DEATH (Enter only one c.)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

171X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)
} DUE TO
} (c)

Hydrocephalus

Carcinoma of cervix

INTERVAL BETWEEN
ONSET AND DEATH

3 months

2 yrs

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

None

19. WAS AUTOPSY
PERFORMED?YES NO 20e. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.Month, Day, Year
19
White
at work Not White
at work 20d. INJURY OCCURRED
20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 1st, 1961, to Sept. 7, 1961, that (I) (we) last saw the deceased alive on Sept. 8th, 1961, and that death occurred 3:30P.M. from the causes and on the date stated above.

22a. SIGNATURE

Ralph C. Michels

22b. DATE
SIGNED

9/11/61

22c. PHYSICIAN'S
NAME (Type)

R.L. Michels, M.D.

M.D. ATTENDING
PHYS. MED. DIRECTOR STAFF
PHYS.

22d. ADDRESS

Frederick Shopping Center, Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Sept. 12, 1961

23c. NAME OF CEMETERY OR CREMATORIUM

Church of Brethren Cem.

23d. LOCATION (City, town or county)

Frederick Co., Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

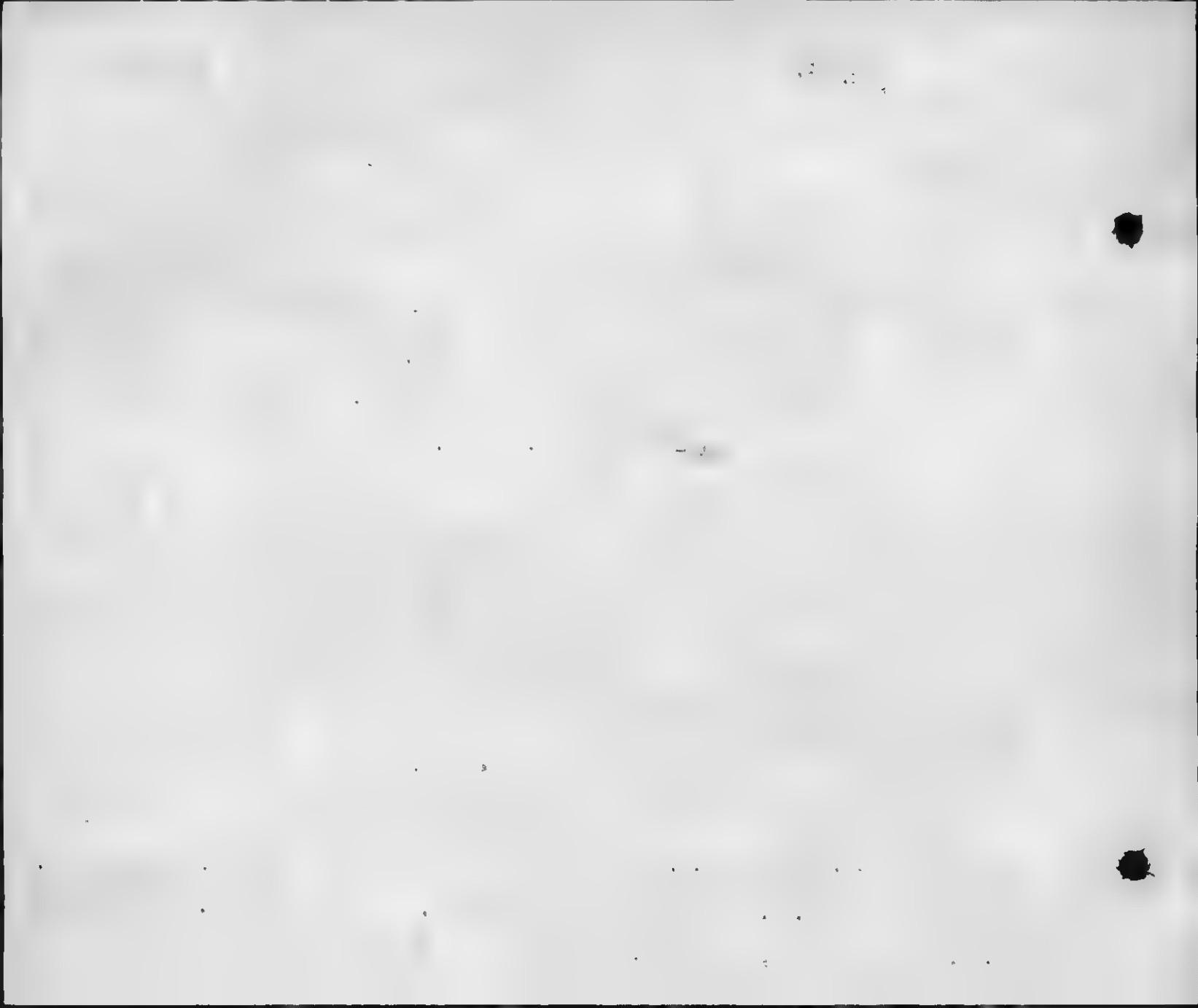
M. R. Etchison & Son, Frederick, Maryland

25a. REC'D BY REGISTRAR

SEP 13 '61
DATE

25b. REGISTRAR'S SIGNATURE

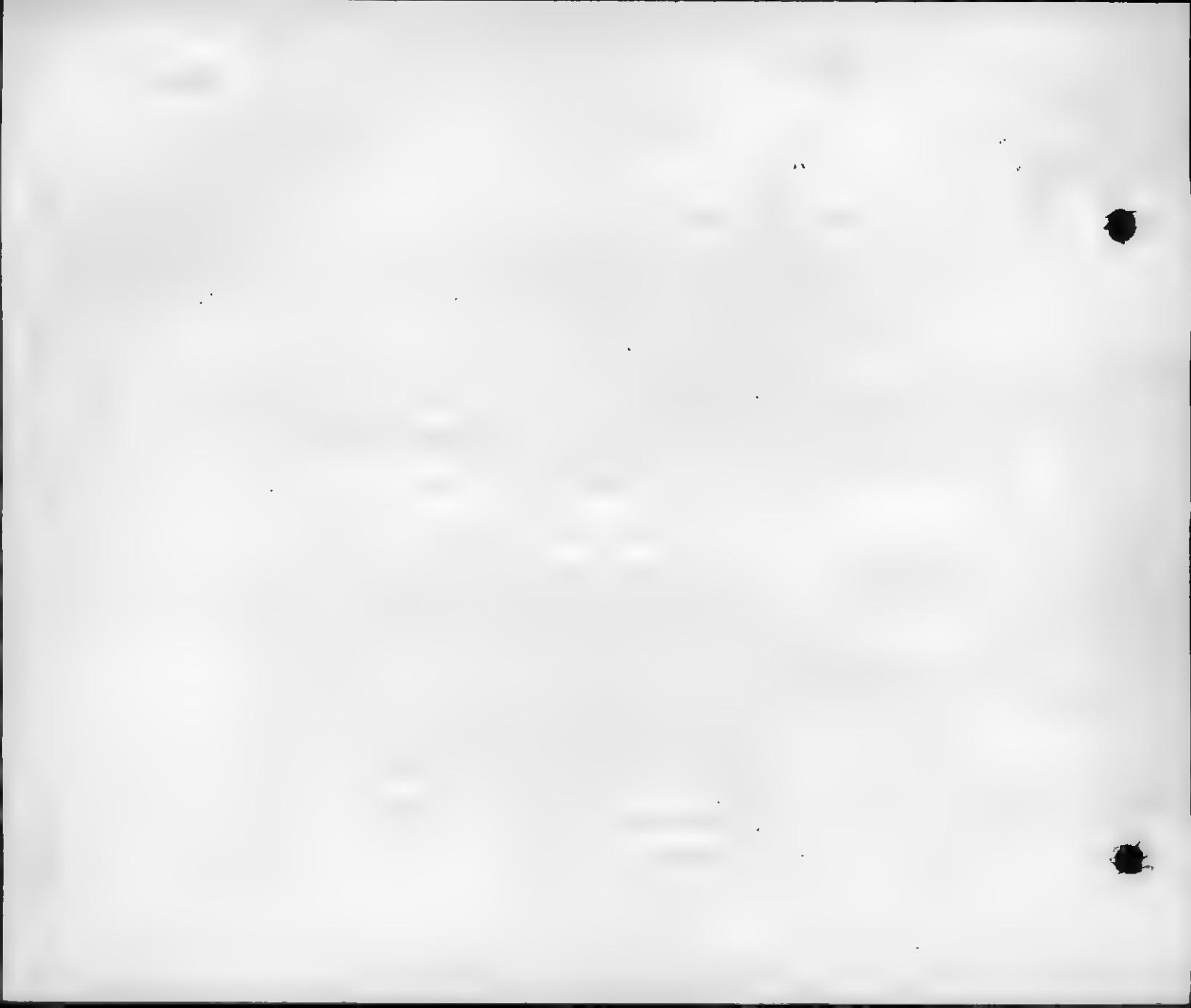
Arthur S. Thrane



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10209				10204							
1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE MD. b. COUNTY CARROLL							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 1 WEEK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR		d. STREET ADDRESS Rt #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL Hosp.											
3. NAME OF DECEASED (Type or print) BARRY		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>27 July 61</i>	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John E. Litchfield				14. MOTHER'S MAIDEN NAME Catherine Colom							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT <i>Hospital Records</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac failure - Cor pulmonale INTERVAL BETWEEN ONSET AND DEATH 24 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intraventricular septal defect 2 mos (c) Anomaly of trachea 2 mos											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>18 Sept 1961 to 20 Sept 1961</i>							
20c. TIME OF INJURY Hour o m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) TAYLORSVILLE		(County)		(State) MD	
21. I certify that (I) (this hospital) attended the deceased from 18 Sept 1961 to 20 Sept 1961 , that (I) (we) last saw the deceased alive on 20 Sept 1961 and that death occurred at 4:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE 				M.D. <input checked="" type="checkbox"/> ATTENDING PHYSICIAN MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>Frederick, Md</i>			
22c. PHYSICIAN'S NAME (Type) F. J. HELDRECHT				22d. ADDRESS <i>Frederick, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/22/61		23c. NAME OF CEMETERY OR CREMATORIAL METHODIST		23d. LOCATION (City, town, or County) TAYLORSVILLE				(State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE <i>N N Hartley & Sons, New Windsor</i>				ADDRESS <i>New Windsor</i>		25a. REC'D. BY REGISTRAR SEP 27 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
100-19X-14											



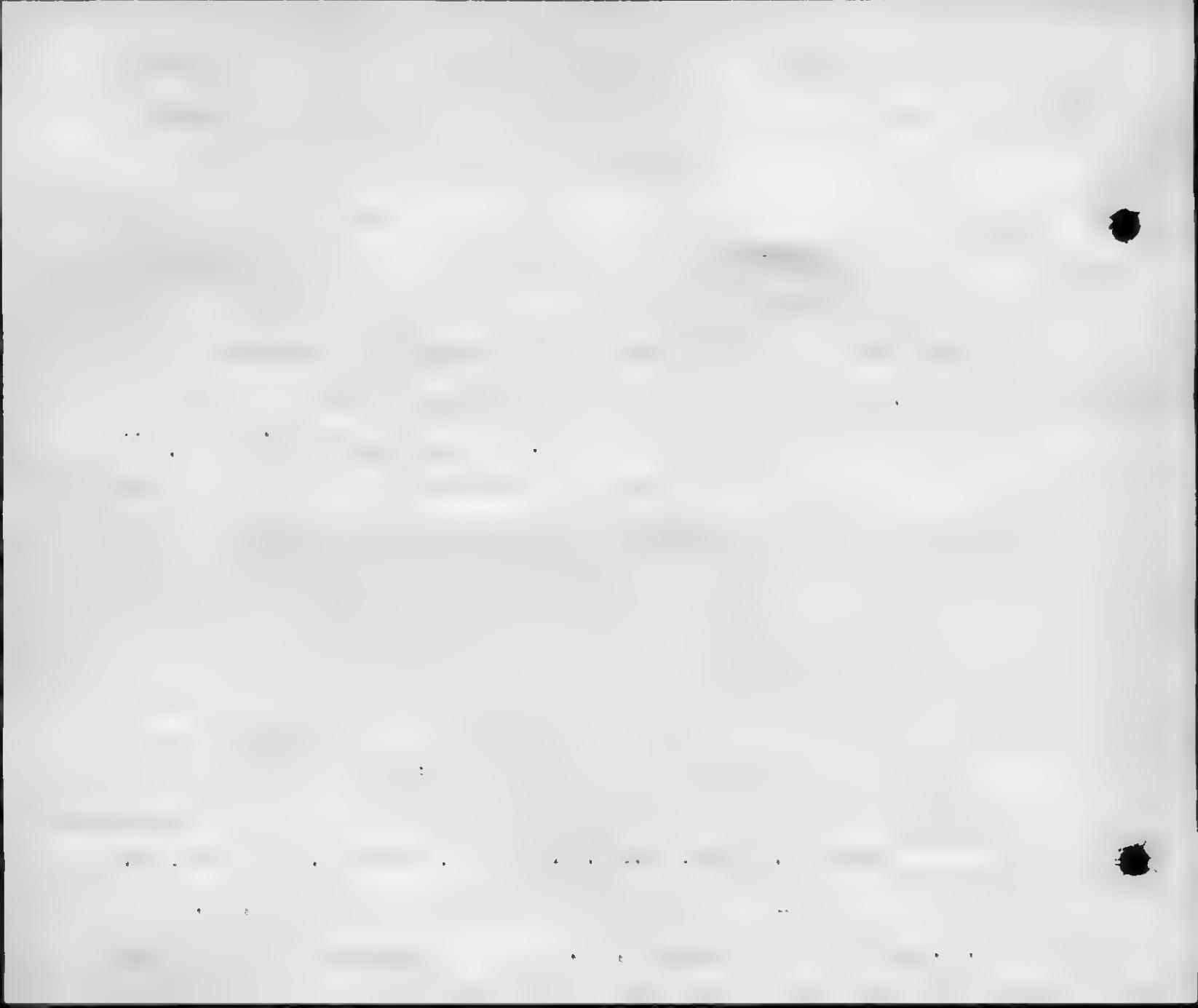
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10205

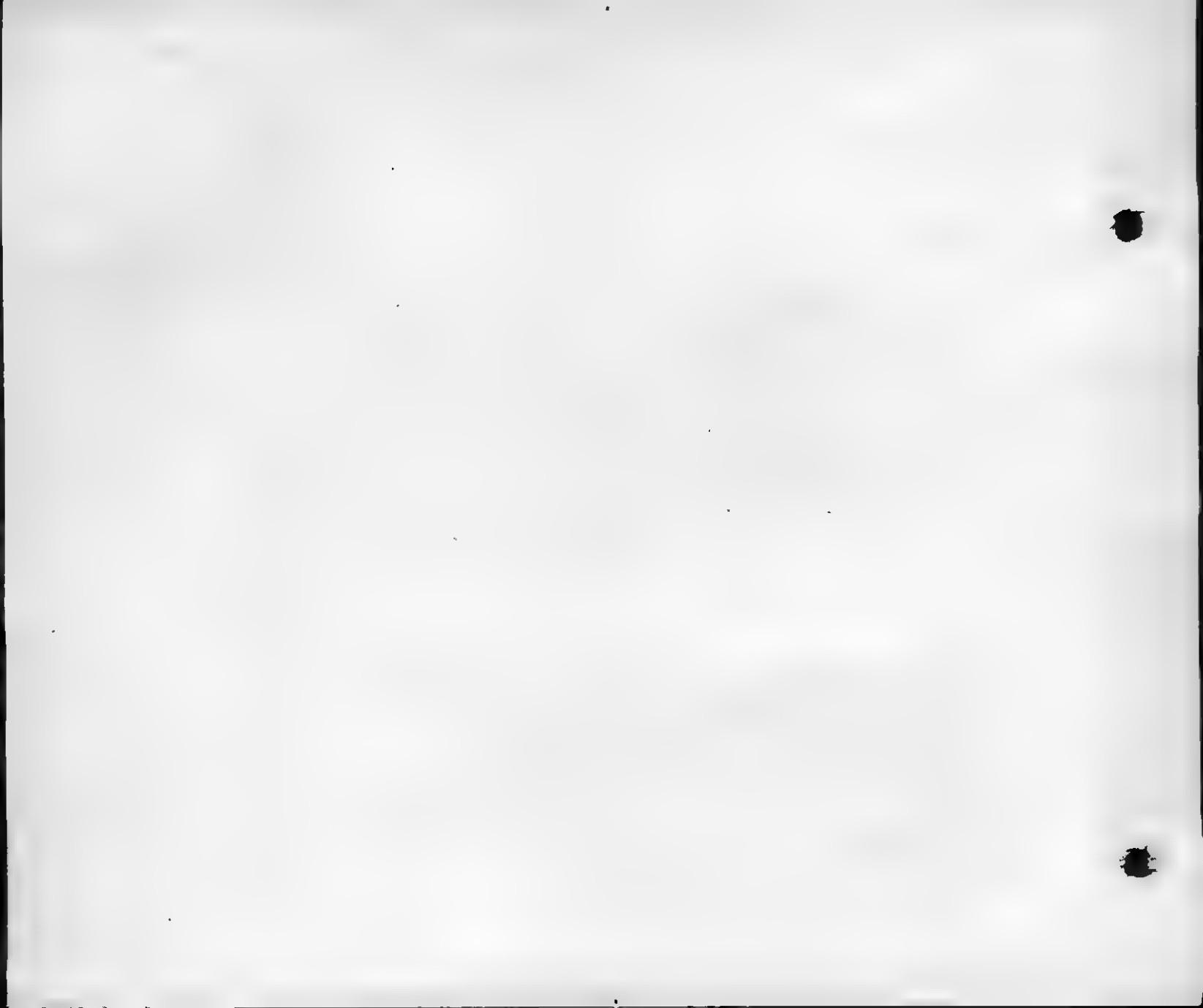
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 70 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 408 Elm Street		d. STREET ADDRESS 408 Elm Street	
e. FIRST MIDDLE LAST BIRDIE MAY MILLER		4. DATE OF DEATH September 15, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 26 April 1875	
9. AGED (in years) IF UNDER 1 YEAR 86 yrs.		10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Frederick County Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David A. Miller		14. MOTHER'S MAIDEN NAME Roberta Johnston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank and dates of service) No		16. SOCIAL SECURITY NO., 17. INFORMANT Unk Mr. Parsons Newman, Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. Anterior - sclerosis (Advanced)		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1 1952 to Sept. 15 1961 , that (I) (we) last saw the deceased alive on Sept. 14 1961 , and that death occurred at 8:45A M, from the causes and on the date stated above.		22b. DATE SIGNED 15 Sept 1961	
22a. SIGNATURE Bernard O. Thomas Jr.		22b. DATE SIGNED 15 Sept 1961	
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-18-61	
23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		25a. REC'D BY REGISTRAR RE 18 '61	
ADDRESS 15M 9/60		25b. REGISTRAR'S SIGNATURE John S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10211		10206	
PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 6 yrs.		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 Frederick - md. d. STREET ADDRESS 1455 West South St.	
3. NAME OF DECEASED (Type or print) Lillie First Middle Last Ethel Minnick		4. DATE OF DEATH 9 18 1961	
5. SEX Female 6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
10c. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years lost birthday) 74 yrs.	
13. FATHER'S NAME Robert Crone		14. MOTHER'S MAIDEN NAME May Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220-18-0512	
17. INFORMANT Mrs. Mary Richards, 231 N. Market St., Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 260X		chronic Cardio Vascular disease 6 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Diabetes Mellitus 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1957 to Sept. 18, 1961 , that (I) (we) last saw the deceased alive on Sept 18 1961 , and that death occurred at 9 PM , from the causes and on the date stated above		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE H.F.Kline		22b. DATE SIGNED Sept 19 61.	
22c. PHYSICIAN'S NAME (Type) H.F.Kline MD.		22d. ADDRESS FREDERICK MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/21/1961	
23c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Middletown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		25a. REC'D BY REGISTRAR SEP 25 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10212

10207

1. PLACE OF DEATH

e. COUNTY

Frederick

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

e. STATE

Maryland

b. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN b.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

d. STREET ADDRESS

Point of Rocks

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
SeptemberDay
15, 1961

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

January 22, 1906

9. AGE (in years
last birthday) 10. IF UNDER 1 YEAR
55 yrs. Months Days Hours Min.10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Restraint employee

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country)

Point of Rocks, Maryland

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13. FATHER'S NAME

Oscar Franklin Mock

14. MOTHER'S MAIDEN NAME

Lena Monzella

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Mary Ellen Mock Point of Rocks, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)416 X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
} (b)
} DUE TO
} (c)
} DUE TOINTERVAL BETWEEN
ONSET AND DEATH

31-41-ja

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,
p.m. 19 While Not White factory, street, office bldg., etc.)
at work at work

20f. (City or town) (County) (State)

21. I certify that (I) (the deceased) attended the deceased from 9-15-1961 to 9-15-1961, that (I) (we) last
saw the deceased alive on 9-15-1961, and that death occurred at M, from the causes and on the date stated above.22b. DATE
SIGNED
9-16-1961

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Dr. C. E. Pruitt

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

M.D. 25 Petersville Road Brunswick, Maryland

23e. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Burial

9-19-1961

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

St. Paul's Cemetery

Point of Rocks, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Robert E. Dailey & Son

ADDRESS

Frederick, Maryland

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

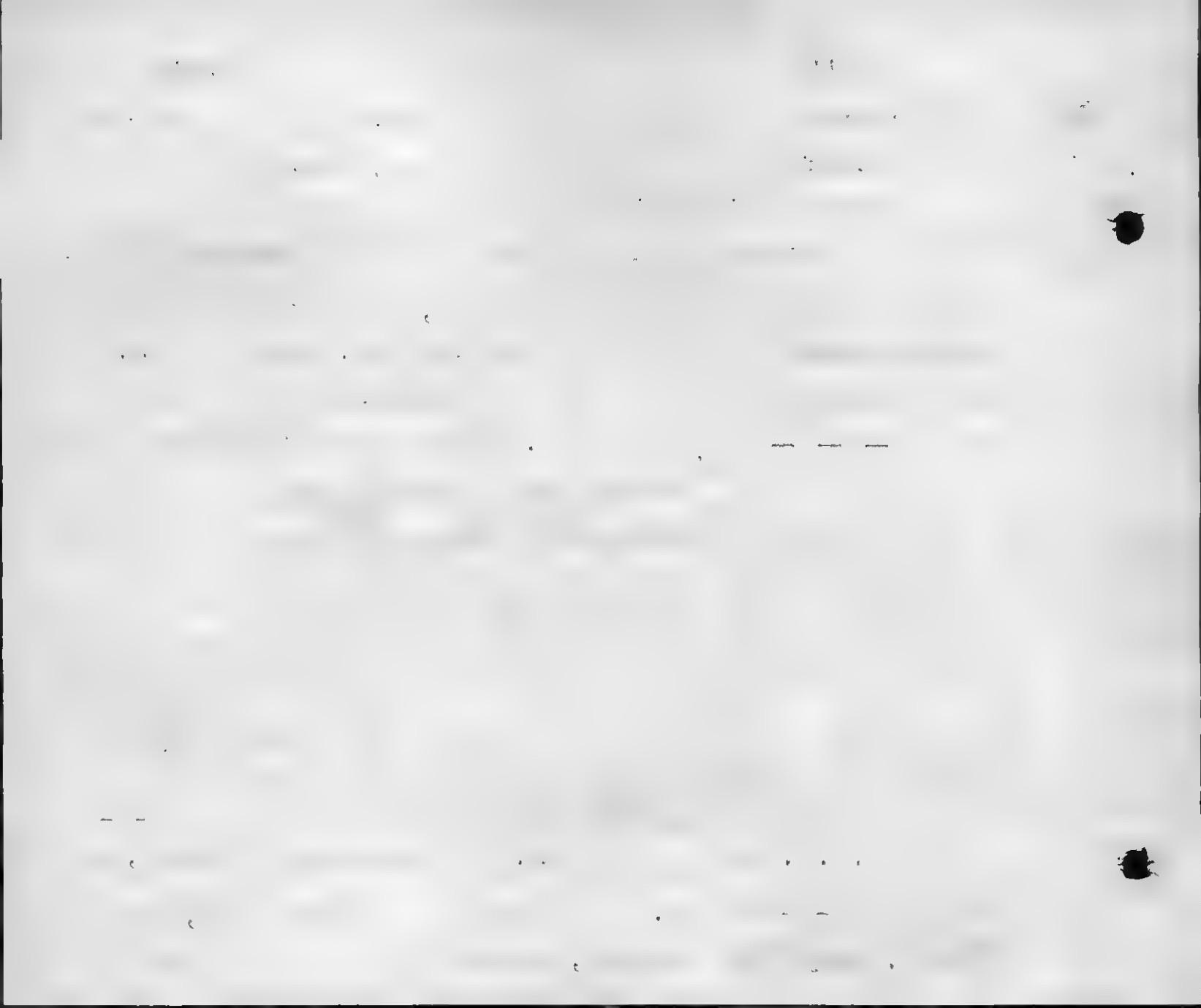
Sep 21 '61

Charles S. Times

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours cannot be spared by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1
M
I
VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

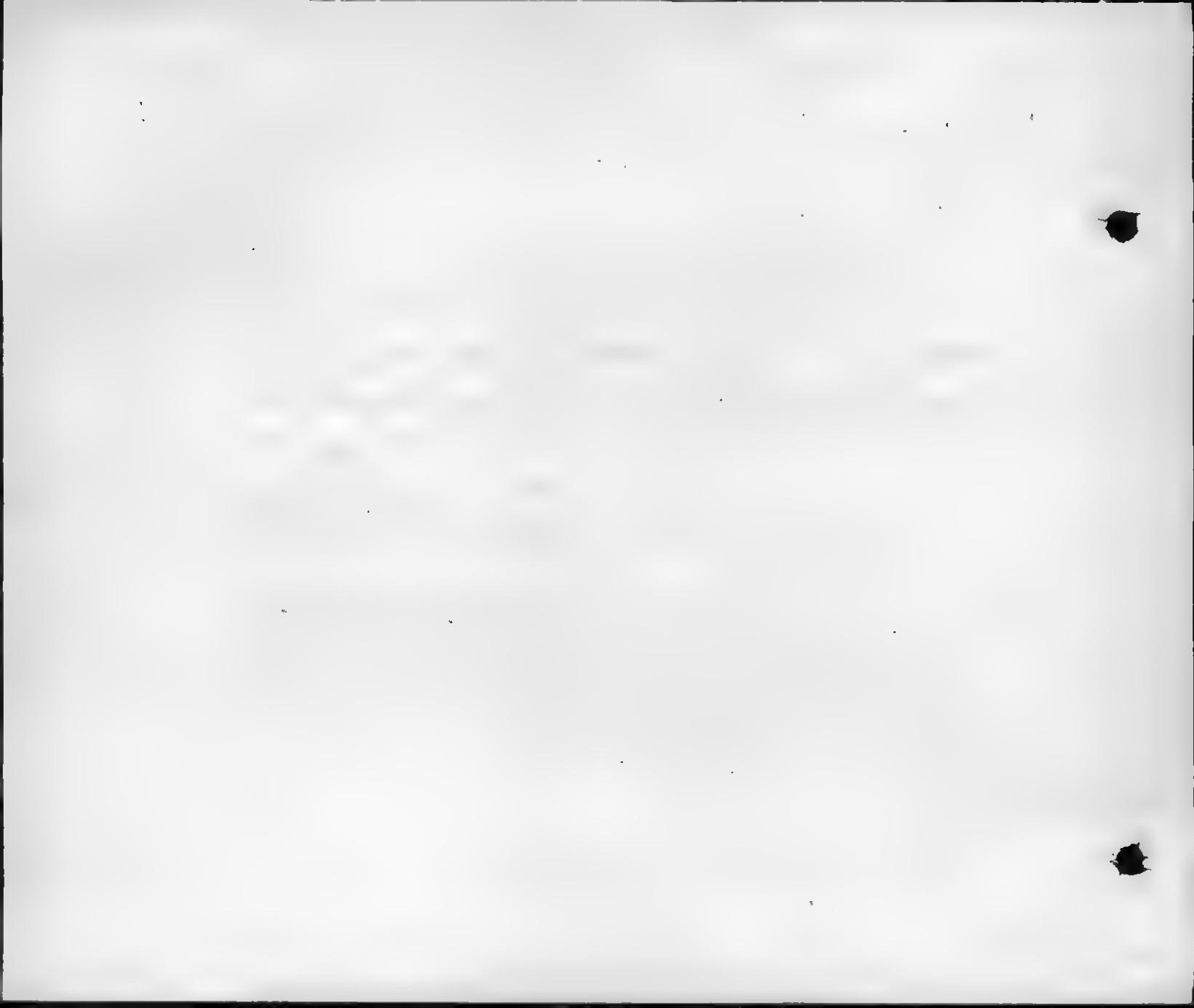
CERTIFICATE OF DEATH

M

10213

10208

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>7 wks.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Daysville</i>		d. STREET ADDRESS <i>1</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>FLORENCE</i>		First <i>MISOURI</i>	Middle <i>MORGAN</i>	Lost	4. DATE OF DEATH <i>SEPT. 24 1961</i>	Month	Day	Year			
S. SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 1st 1878</i>	9. AGE (In years lost birthday) <i>83 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Bradley Smith</i>		14. MOTHER'S MAIDEN NAME <i>Mary Houck</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO <i>—</i>		17. INFORMANT <i>Mr. Lee W. Morgan, 27 Fahey Ct., Frederick, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4 10.0</i>		DUE TO <i>acute coronary artery thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i>		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe arteriosclerotic heart disease yrs.</i>					
DUE TO <i>Severe arteriosclerotic heart disease yrs.</i>		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>fracture of neck left femur 8/8/61</i>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that (I) (this hospital) attended the deceased from <i>8/8/61</i> to <i>9/24/61</i> , that (I) (we) last saw the deceased alive on <i>9/23/61</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.		22a. SIGNATURE <i>Frank Damazo Jr</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>9/24/61</i>		
22c. PHYSICIAN'S NAME (Type) <i>Frank Damazo Jr</i>		22d. ADDRESS <i>7 w. 3rd st Frederick</i>									
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/26/61</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Chapel Cemetery</i>		23d. LOCATION (City, town, or county) <i>Mt. Liberytown</i>		(State) <i>Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>T. C. Barton, Walkersville, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>SEP 26 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Klaus</i>					



FOR STATE
HEALTH DEPT.



TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10214 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First CLARENCE

Middle WILLIAM

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

September 10, 1906

9. AGE (in years
last birthday) 55

IF UNDER 1 YEAR
Months 0

Years 55

IF UNDER 24 HRS.
Hours 0

Min. 0

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Penna.

13. FATHER'S NAME

Harry Mull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

204-01-3501 Mrs. Naomi M. Mull-Same as item #2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

ACUTE CORONARY ARTERY THROMBOSIS

RECENT MYOCARDIAL INFARCT

ARTERIOSCLEROSIS HEART DISEASE

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

9/25/61

ACTUAL
SIGNATURE

B. O. Thomas, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or country)

(State)

Mercersburg,

Penna.

Burial Sept. 27, 1961

Fairview Cemetery

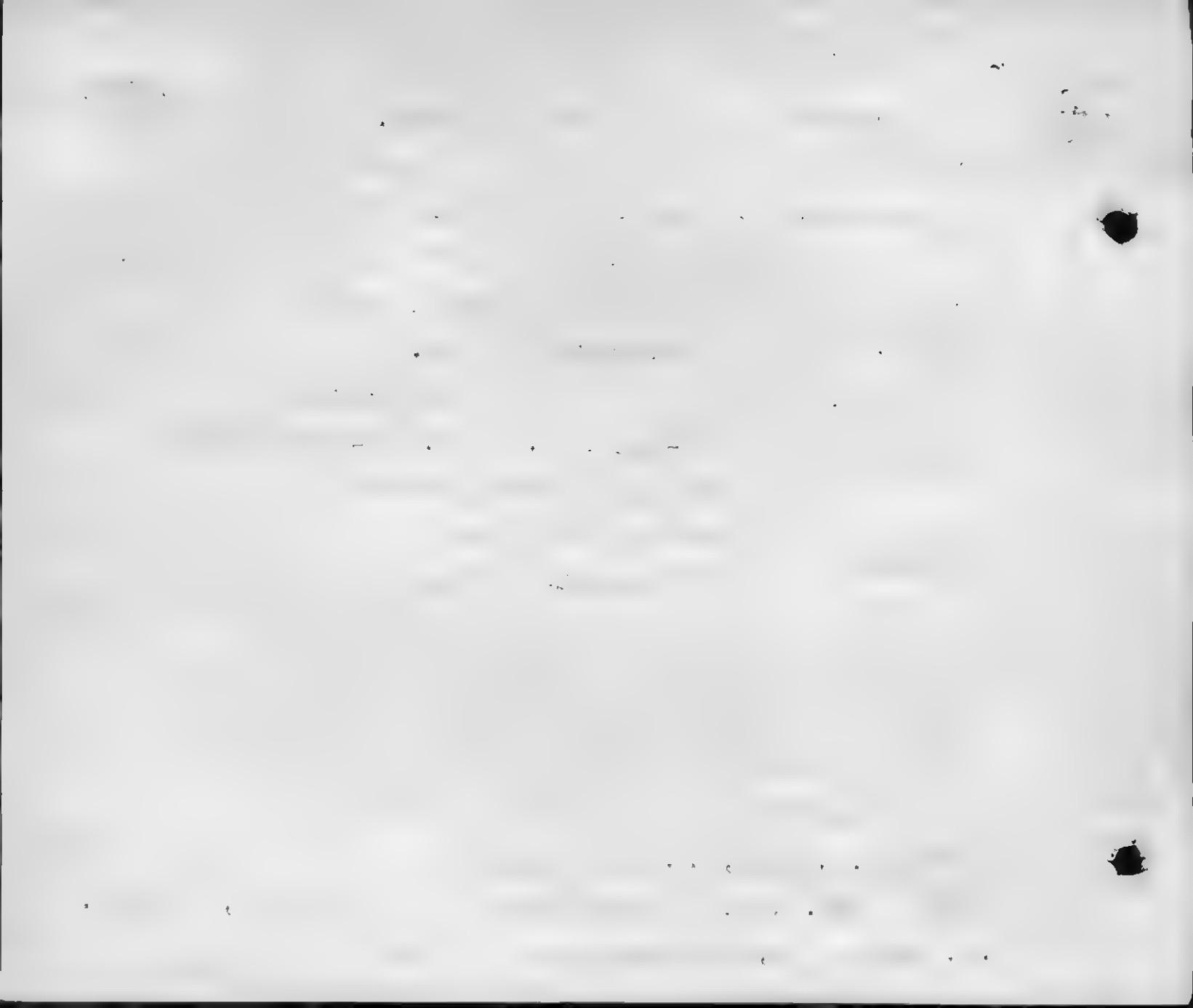
24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE SEP 27 '61

Clinton S. Thomas

VS. A15ME
SM 7/59



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10215

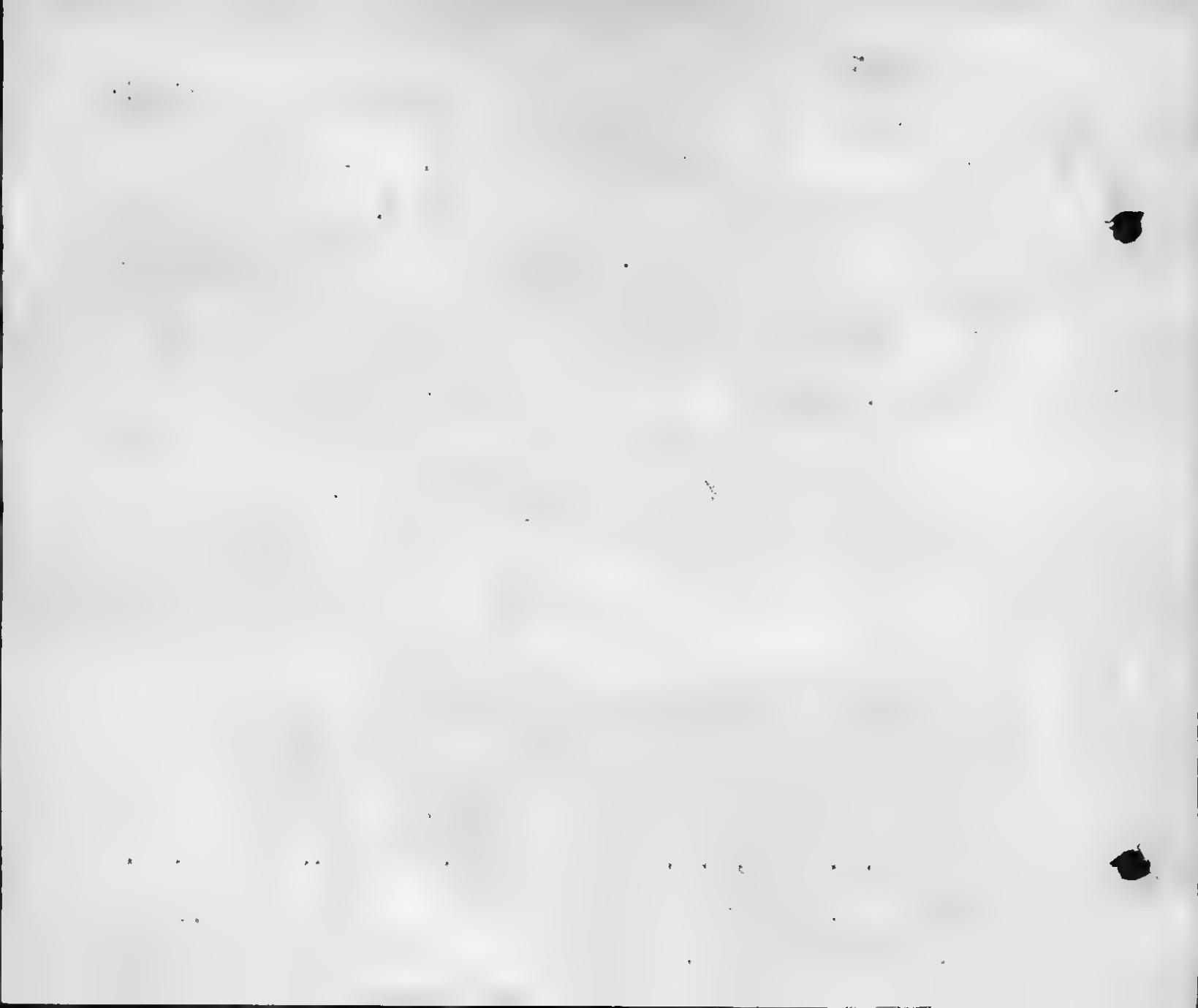
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If more than 24 hours elapse between the time of death and the time the physician signs the certificate, it must be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institutional, state name and date admission) b. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 10/22/53	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland Odd Fellows Home		X Mt. Airy - Rural	
3. NAME OF DECEASED (Type or print) LENNA		d. STREET ADDRESS Near Mt. Airy	
First L	Middle M.	Last NAILL	4. DATE OF DEATH September 20, 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Sept 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		9. AGE (in years at birthday) IF UNDER 1 YEAR 84 yrs. IF UNDER 24 HRS. Months Deys Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Charles T. Chaney		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service) No		16. SOCIAL SECURITY NO. None	
		17. INFORMANT Maryland Odd Fellows Home (Same as item #1)	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 1. Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2. Arterosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH months years	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20 Sept 21, 1961	
p.m.		(City or town) Frederick, Md. (County) Maryland (State) MD	
21. I certify that (I) (this hospital) attended the deceased from Sept 20, 1961 to Sept 21, 1961 that (I) (we) last saw the deceased alive on Sept 20, 1961 , and that death occurred at 9 AM , from the causes and on the date stated above.		22b. DATE SIGNED 20 Sept 1961	
22e. SIGNATURE B. O. Thomas, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M.D.		22d. ADDRESS 228 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-23, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Prospect Cemetery C. M. WALTZ, WINFIELD, MARYLAND		23d. LOCATION (City, town or county) (State) Frederick Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ, WINFIELD, MARYLAND		25a. REC'D BY REGISTRAR Arthur J. Haas	
		25b. REGISTRAR'S SIGNATURE Arthur J. Haas	
		DATE SEP 22 '61	



112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the physician or attending physician and completely filled in by the funeral director.

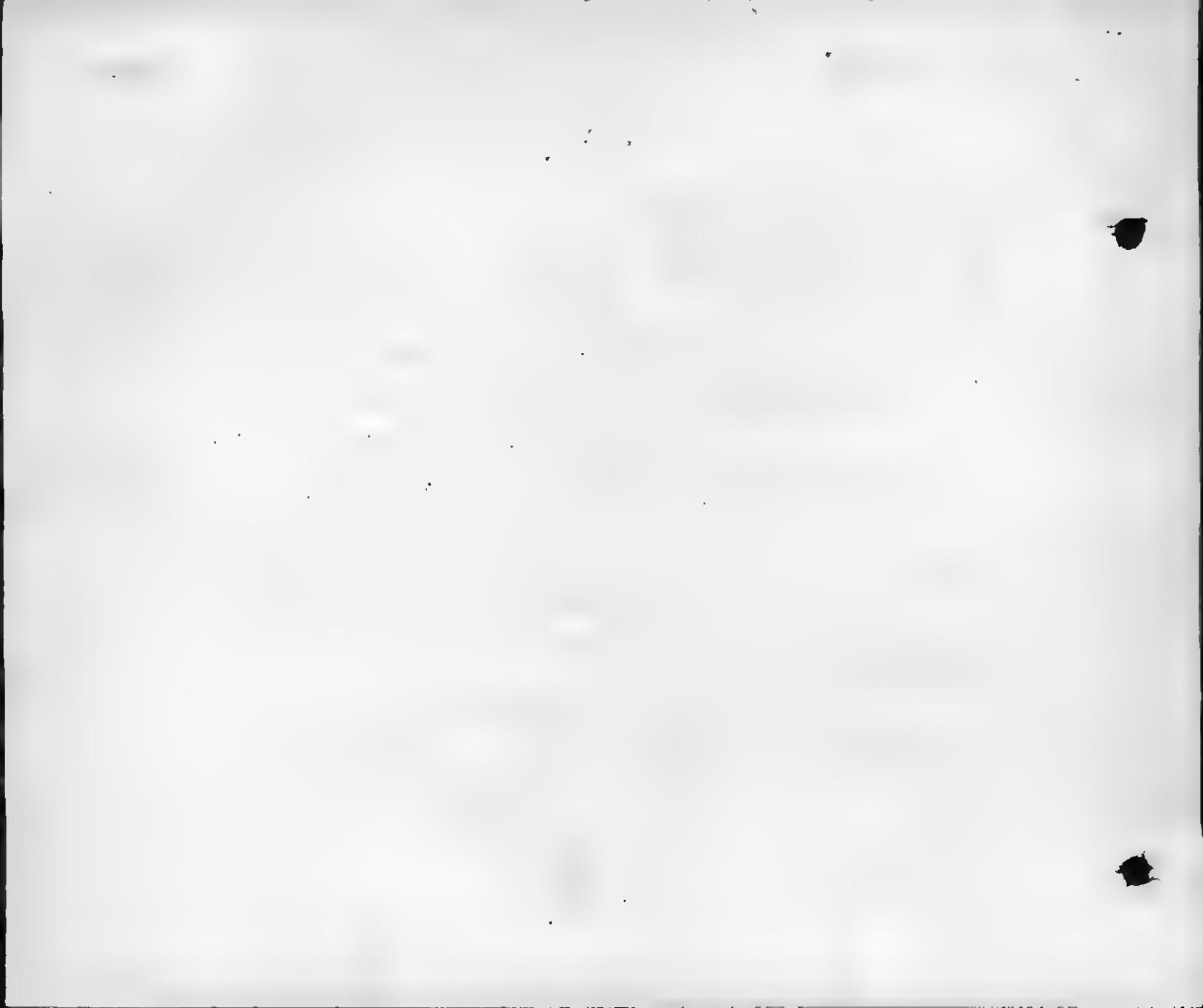
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10211

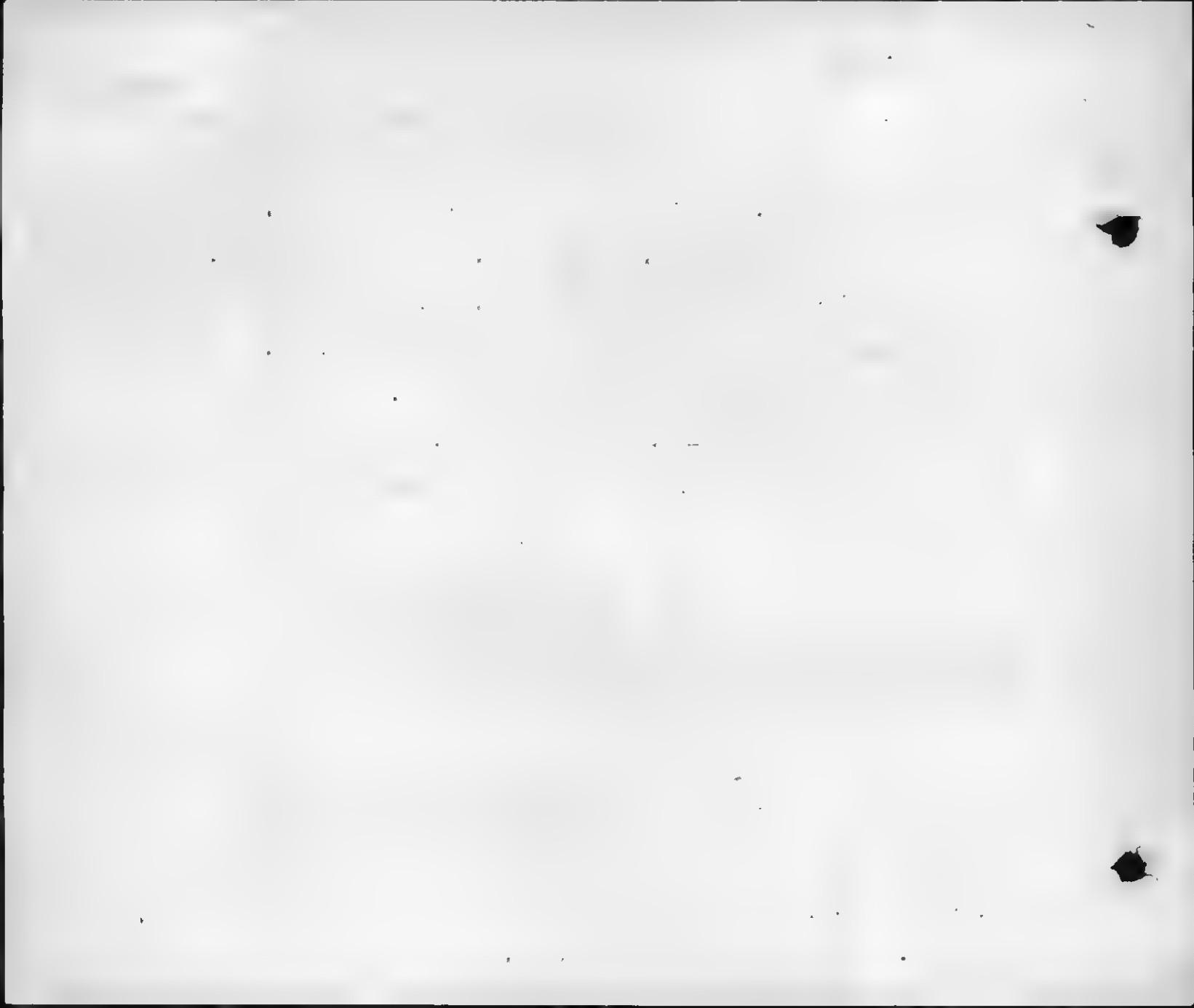
1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		b. COUNTY CDY.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODBINE		d. STREET ADDRESS WOODBINE MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elinor	Middle B.	Last Neumann	4. DATE OF DEATH Sep. 21	Month Sep.	Day 21	Year 1961
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 31, 1901	9. AGE (In years last birthday) 60	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 60	Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MICH.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BIENEMANN		14. MOTHER'S MAIDEN NAME UNKNOWN		Address MR. William NEUMANN, WOODBINE MD.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)							
16. SOCIAL SECURITY NO.							
17. INFORMANT							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) Infarction of the brain Thrombosis of the left middle cerebral artery c) Meningitis, Pneumococcal 3 WKS INTERVAL BETWEEN ONSET AND DEATH 3 WKS 2 WKS 3 WKS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 29 , 1961, to Sep 21 , 1961, that (I) (we) last saw the deceased alive on Sep 30 , 1961, and that death occurred at 5:45 AM , from the causes and on the date stated above							
22a. SIGNATURE Henry V. Chase		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Sep 31, 1961			
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 4 E. Church st Frederick Md					
23a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		23b. DATE THEREOF 9/25/61		23c. NAME OF CEMETERY OR CREMATORIAL ST. PAUL'S		23d. LOCATION (City, town, or county) (State) VIOLETTVILLE MD	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE F.D. 4101 EDNIONDSON AVE				ADDRESS		25a. REC'D BY REGISTRAR DATE Sep 25 '61	
						25b. REGISTRAR'S SIGNATURE Orchard & Koenig	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10217				10212							
1. PLACE OF DEATH a. COUNTY <i>FREDERICK</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Maryland</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. LENGTH OF STAY IN 1b <i>1 day</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Damascus</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Mem. Hospital</i>				d. STREET ADDRESS <i>27431 Ridge Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Russell V. Oden, Sr.</i>				First	Middle	Last	4. DATE OF DEATH <i>Sept. 2</i>	Month	Day	Year	
5. SEX Male 6 COLOR OR RACE <i>White</i>				7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb. 14, 1907</i>				9 AGE (In years last birthday) <i>54</i> yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>New Market, Md.</i>				11. BIRTHPLACE (State or foreign country) <i>New Market, Md.</i>			
13. FATHER'S NAME <i>Washington Brewer Oden</i>				14. MOTHER'S MAIDEN NAME <i>Emma C. Thompson</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-16-7833</i>		17. INFORMANT <i>Mrytle A. Oden</i>		Address <i>Item 2</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Deformated glycemic disease</i> (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) <i>New Market, Md.</i>		(County) <i></i>		(State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>9/1/1961</i> to <i>9/2/1961</i> , that (I) (we) last saw the deceased alive on <i>9/2/1961</i> , and that death occurred at <i>5 AM</i> , from the causes and on the date stated above											
22a. SIGNATURE <i>Robert H. Pilgram</i>						22b. DATE SIGNED <i>9/3/61</i>					
22c. PHYSICIAN'S NAME (Type) <i>Robert H. Pilgram, M.D.</i>						M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>Pro F. Blalg</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/4/61</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>New Market</i>				23d. LOCATION (City, town, or county) <i>New Market, Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Wobensmith</i>		ADDRESS <i>Damascus, Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 6 '61</i>				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurs after 4 p.m., it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

10218

10213

1. PLACE OF DEATH

b. COUNTY
Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate 1 mils, write RURAL and give nearest town)

Lewistown

c. LENGTH OF STAY IN lb

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Own Home

3. NAME OF
DECEASED
(Type or print)

First

George

Middle

Miller

Last

Palmer

4. DATE
OF
DEATH

Sept. 12. 1961

Month

Day

Year

19

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Nov. 21. 1911

9. AGE (In years
at time of death)

49

yr.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Fish Culturist

10b. KIND OF BUSINESS OR INDUSTRY

State od Md

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

G. Lloyd Palmer

14. MOTHER'S MAIDEN NAME

Mamie Deleplane Miller

Address

Lewistown md

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (Type or print date of service)

Yes W.W. 2

16. SOCIAL SECURITY NO.

219-36-2737

17. INFORMANT

Evalene F. Palmer.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Acute myocardial infarction

Arterio-sclerotic coronary art. dis.

INTERVAL BETWEEN
ONSET AND DEATH

1 1/2 hrs.

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITON GIVEN IN PART I.a) 19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11 Sept. 1961 to 12 Sept. 1961, that (I) (we) last saw the deceased alive on 12 Sept. 1961 and that death occurred 12 Sept. 1961 A.M. from the causes and on the date stated above.

22. SIGNATURE

Charles H. Conley Jr.

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

22b. DATE SIGNED

13 Sept. 61

Frederick. MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial Sept. 15. 1961

23c. NAME OF CEMETERY OR CREMATORIUM

Mt. Olivet Gem.

23d. LOCATION (City, town or county)

Frederick Fredk. Co. Md

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Raymond E. Stinger

ADDRESS

Thurmont. Md

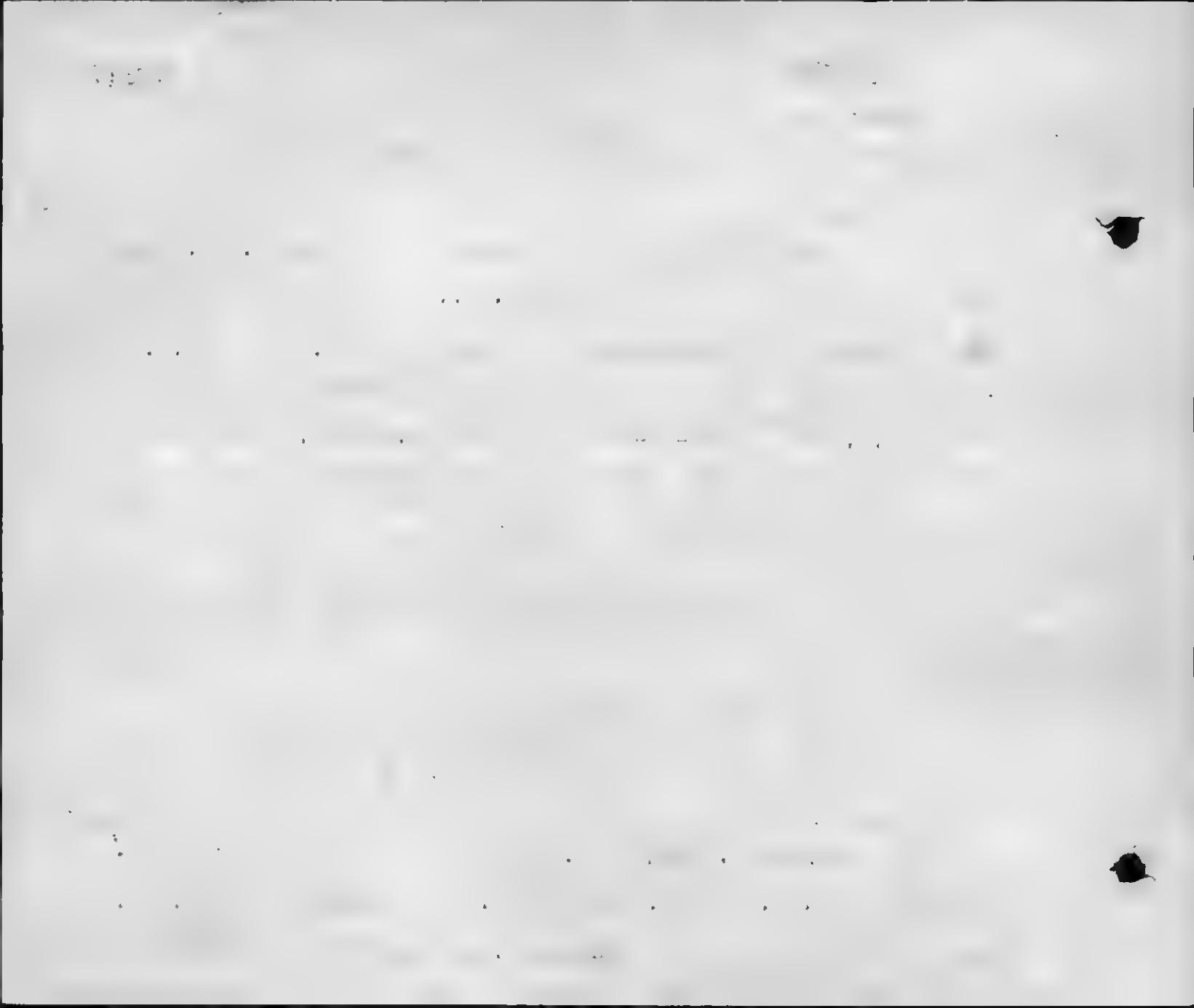
25a. REC'D BY REGISTRAR

DATE SEP 18 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

1



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10219

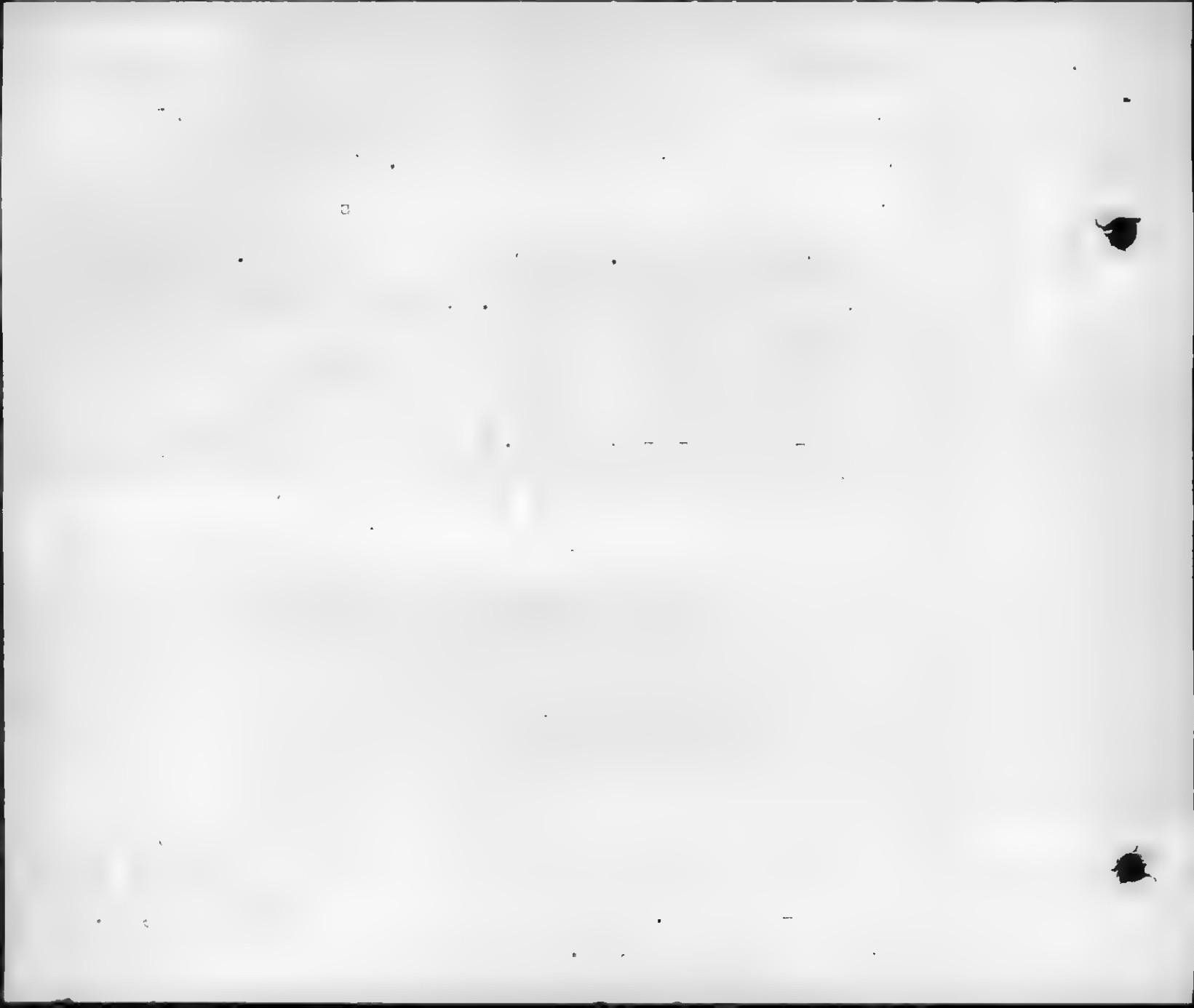
CERTIFICATE OF DEATH

10214

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN b. 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) #2 Mt. Airy		d. STREET ADDRESS Warfield Acres					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial				d. STREET ADDRESS Warfield Acres		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) George		First A.	Middle Porteous	Last Sept. 1, 1880	4. DATE OF DEATH Sept. 29, 1961	Month Sept.	Day 29	Year 1961			
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1880	9. AGE (In years last birthday) 81 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Livestock Consultant		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ronald Porteous		14. MOTHER'S MAIDEN NAME Elizabeth Stenhouse									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-30-7677		17. INFORMANT Mrs. George Porteous		Address Same as 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 177 X Conditions, if any, which gave rise to immediate cause (b), stating the under-lying cause lost. DUE TO		Carcinoma of the prostate with generalized metastases						INTERVAL BETWEEN ONSET AND DEATH		2 yrs	
DUE TO		(b)									
DUE TO		(c)									
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Sep 6, 1961 to Sep 29, 1961 , that (I) (we) last saw the deceased alive on Sep 28, 1961 , and that death occurred at 3:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE Henry V. Chase		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22b. DATE 9/29/61	
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 4 E. Church St Frederick, Md.									
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-29-61		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		23d. LOCATION (City, town, or county) Prince George County, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Francie H. Barber Laytonsville, Md.		ADDRESS		25a. REC'D BY REGISTRAR OCT 2 '61		25b. REGISTRAR'S SIGNATURE Gilmore & Sons					

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Attending Physician: May be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10220

10215

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Jefferson, Md. 23 months

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Glenmerrie Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Bertie

J.

Potterfield

4. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

March 18. 1870

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Virginia

13. FATHER'S NAME

C. W. Fry

14. MOTHER'S MAIDEN NAME

Annie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give year or dates of service)

Address

Harry S. Potterfield - Lovettsville, Va

INTERVAL BETWEEN
ONSET AND DEATH
1 week

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Cerebral accident

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

arterio Sclerotic Nephritis

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/24, 1961, to 9/8, 1961, that death occurred at 9:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

W.B. Carpenter

22b. DATE
SIGNED
21/9/61

22c. PHYSICIAN'S
NAME (Type)

Dr. W. B. Carpenter

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.



FOR STATE
HEALTH DEPT

Delay is necessary,
General director. Page
needed for your files.
The Board of Health,


death
and 31
may b
2 with
opulat

This certificate should be executed within 24 hours after word "pending" in pencil in Item 18. Give Pages 1, 2, Medical Examiner's Office along with form PM3. Page 5 should be used as a burial-transit permit. File pages 1 and cremation, or removal, and in any event within 72 hours.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10221

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, name and address)		10-216	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		MARYLAND		b. STATE Maryland		b. COUNTY Frederick	
Thurmont rural		c. LENGTH OF STAY IN 16 32 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Own Home		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day
Samuel		Howard	Rickerd		Sept. 14	19	61
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
male		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 7, 1890	70		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Own Farm		Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Mary Hart		Address	
Silas Rickerd		None		Ruth V. Rickerd		Thurmont, Md. RD 2	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or dates of serv etc.		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH Minutes	
Yes WVL				Mary Hart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		None Ruth V. Rickerd			
		Coronary Occlusion					
42 J. /		DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)					
		DUE TO					
		(c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>B.O. Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)		MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
B.O. Thomas		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE SIGNED 9-11-61					
22b. DATE THEREOF 9-17-61		Address (Street, city, town, or county)					
22c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cemetery		22d. LOCATION (City, town, or country) Thurmont, Maryland					
23. FUNERAL DIRECTOR <i>Raymond E. Wagner</i>		ADDRESS Thurmont, Md.					
24a. REC'D BY REGISTRAR SEP 18 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10222

CERTIFICATE OF DEATH

10217

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Middletown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN lb

2 years

2. USUAL RESIDENCE (Where deceased lived, if institution, last address before admission)

a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Middletown

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year
19 61

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

female

white

WIDOWED DIVORCED

3/19/1901

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

George E. Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

no

16. SOCIAL SECURITY NO.

none

14. MOTHER'S MAIDEN NAME

Fannie Haupt

Address

Calvin F. Routzahn, Middletown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

2 hr

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)
} DUE TO
} (c)
} DUE TO

Arteriosclerosis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not While at work 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Sept 28, 1961, to Sept 28, 1961, that (I) (we) last
saw the deceased alive on Sept 28, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Elmer Harp

22b. DATE
SIGNED22c PHYSICIAN'S
NAME (Type)

Dr. J. Elmer Harp

ATTENDING
PHYS. MED
DIRECTOR STAFF
PHYS. 23a. BURIAL, CREMATION, REMOVAL
(Specify)

burial

23b. DATE THEREOF

10/1/1961 Lutheran Cemetery

23d. LOCATION (City, town or county)

(State)

Middletown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Gladhill Company, Middletown, Md.

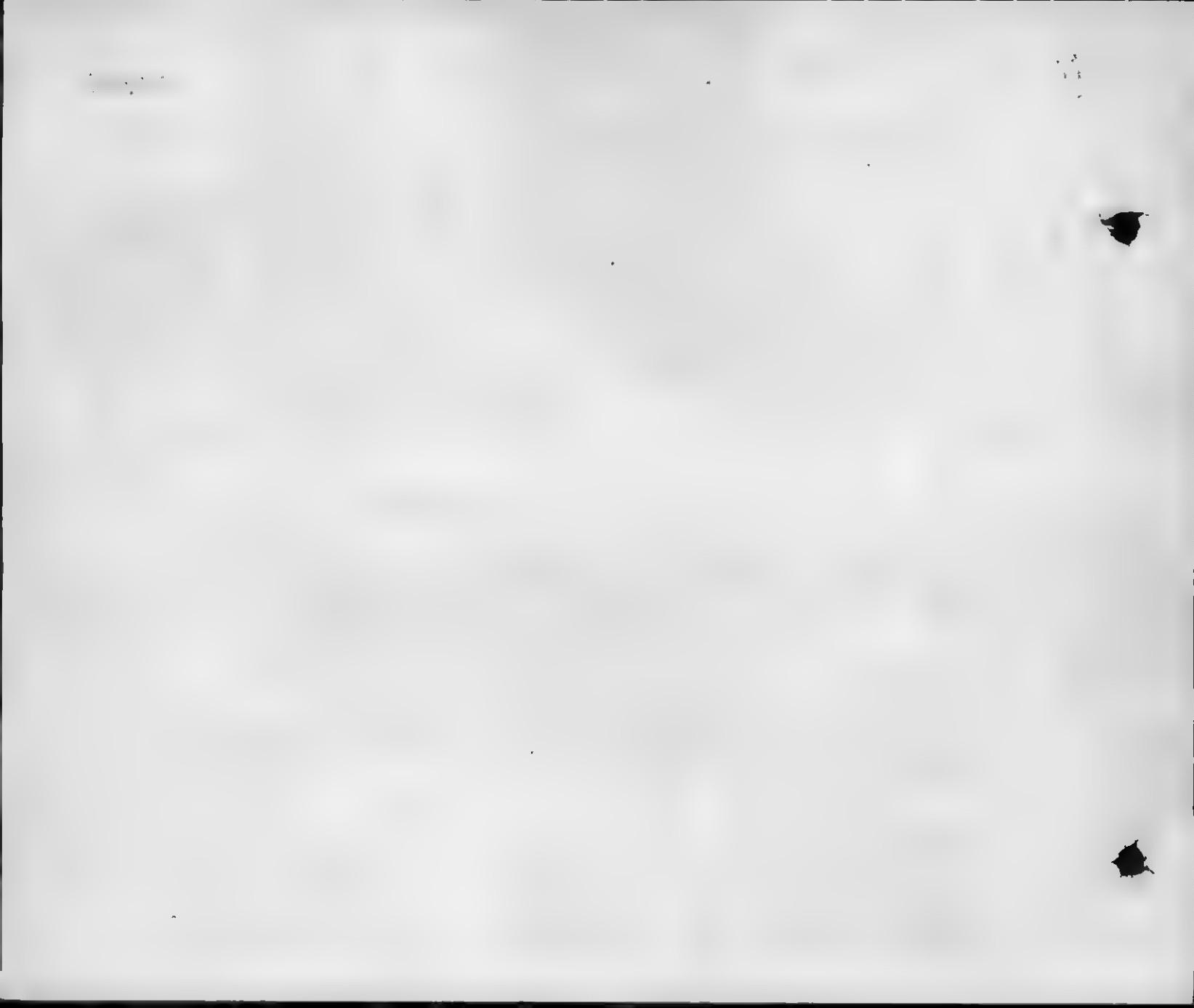
ADDRESS

25e. REC'D BY REGISTRAR

DATE OCT 3 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Harp



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10223

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence of last commission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Robert Franklin Routzahn		First	Middle	Last	4. DATE OF DEATH Sept. 22 1961	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1934		9. AGE (In years last birthday) 27 yrs.	10. IF UNDER 1 YEAR; IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY transportation co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Calvin F. Routzahn		14. MOTHER'S MAIDEN NAME Lulu Long						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Calvin F. Routzahn, Middletown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Coronary Occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH 2 hrs		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Middletown		(County) Maryland (State) Md.
21. I certify that I attended the deceased from Sept 22, 1961 , to Sept 22, 1961 , that I last saw the deceased alive on Sept 22, 1961 , and that death occurred at 3:40 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Middletown		
ACTUAL SIGNATURE <i>J. Elmer Harp</i>		M.D.				DATE SIGNED 9-22-61		
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp		Middletown, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/24/1961		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middletown		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR SEP 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Tamm		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

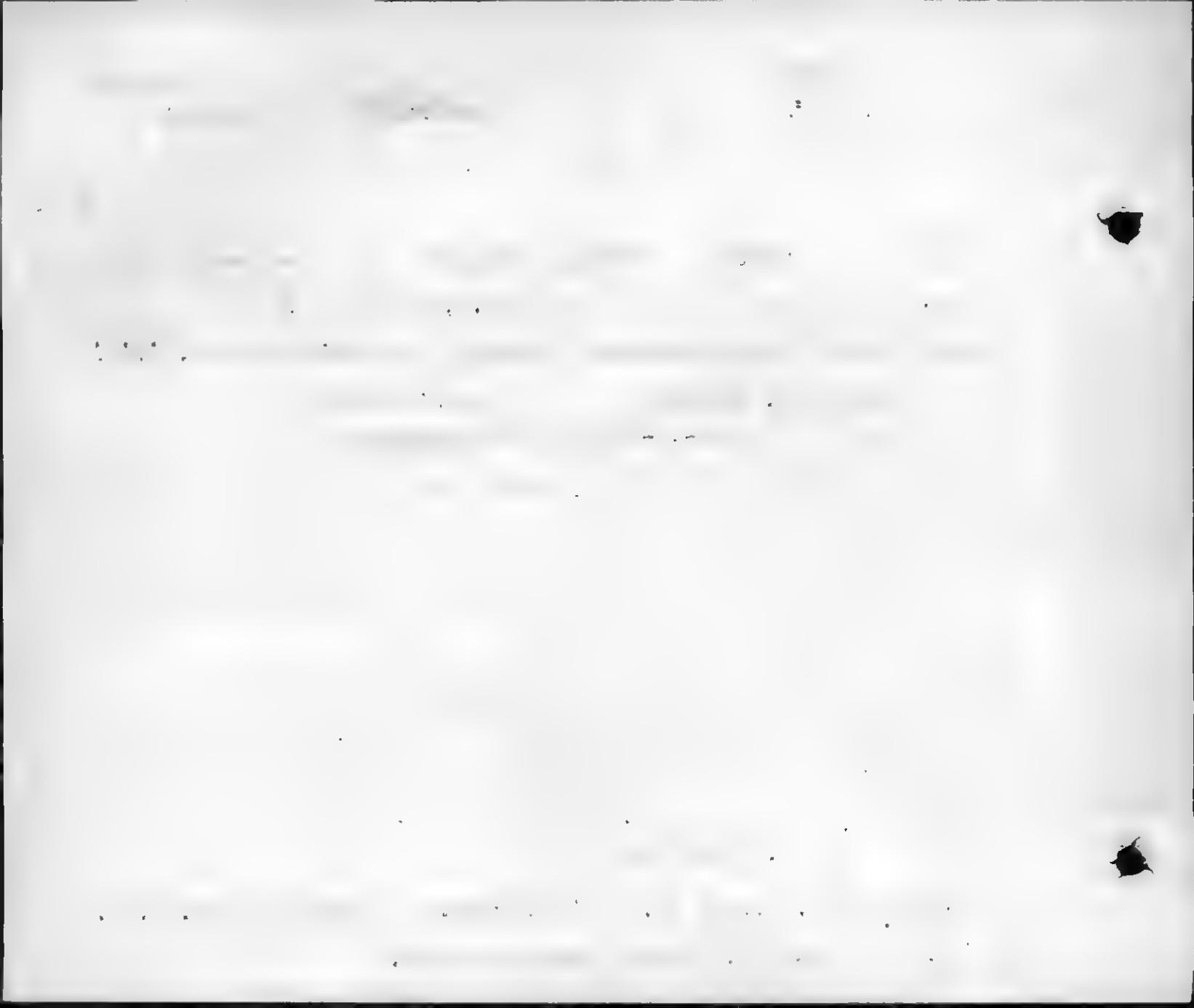


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10219

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence and name of institution) a. STATE Maryland Kingsbury b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville		c. LENGTH OF STAY IN 1b 53 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Myersville	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DANIEL	Middle CARROLL	Last SHEPLEY
4. DATE OF DEATH	Month September	Day 10	Year 1961
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH X Jan. 8, 1908
9. AGE (In years last birthday) 53	10. IF UNDER 1 YEAR yrs. 53	11. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk, Naval ordinance laboratory		10b. KIND OF BUSINESS OR INDUSTRY Myersville, Fred. Co. Md.	
10c. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Melvin F. Shepley		14. MOTHER'S MAIDEN NAME Bessie Butts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown no		16. SOCIAL SECURITY NO. 220-10-5026	INFORMANT Family records
17. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			
DUE TO (c) Arterio Sclerosis.			
INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Heart attack April 1961 Hospitalized at that time.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 10, 1961 , to Sept 10, 1961 , that I last saw the deceased alive on Sept 10, 1961 , and that death occurred at 11:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. Elmer Harp M.D. 9-10-61			
ACTUAL SIGNATURE J. Elmer Harp		PHYSICIAN'S NAME (Type) J. Elmer Harp	
22a. BURIAL, CREMATION, REMOVAL, ETC. Burial		22b. DATE THEREOF Sept. 13, 1961	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Lutheran
22d. LOCATION (City, town, or county) Myersville, Fred. Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		24a. ADDRESS Paul F. Bittle, Myersville, Md.	24b. REGISTRAR'S SIGNATURE Charles S. Thorne
VS A15 (4) 15M 9/58		24a. REC'D BY REGISTRAR SEP 14 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it may be retained by the hospital or attending physician. This certificate should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10225

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

MARYLAND

c. LENGTH OF STAY IN lb

Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

530 Trail Avenue

3. NAME OF
DECEASED
(Type or print)

CHARLES

FRANKLIN

First

Middle

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

June 10, 1881

Last

Month

Day

Year

4. DATE
OF
DEATH
September 27 1961

9. AGE (in years
last birthday)
80 yrs.

10. IF UNDER 1 YEAR
Months Dey

11. IF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Furniture Store

10b. KIND OF BUSINESS OR INDUSTRY

Partner

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles K. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

218-30-9315 Miss Gloria I. Smith, 530 Trail Ave. Fred. Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

42010

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

DUE TO

(b)

DUE TO

(c)

Coronary occlusion

Arteriosclerotic heart disease

INTERVAL BETWEEN
ONSET AND DEATH

Minutes

years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11/27/58, 19..., to 9/27, 1961, that (I) (we) last saw the deceased alive on 6/13, 1961, and that death occurred at 6:30PM from the causes and on the date stated above.

22e. SIGNATURE

James B. Thomas,

22c. PHYSICIAN'S
NAME (Type)

James B. Thomas M.D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
Sept. 28, 1961

22d. ADDRESS

228 North Market St., Frederick, Maryland

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

9-30-1961

23b. DATE THEREOF

Mount Olivet Cemetery

ADDRESS

23c. NAME OF CEMETERY OR CREMATORIUM

Frederick

(State)

Maryland

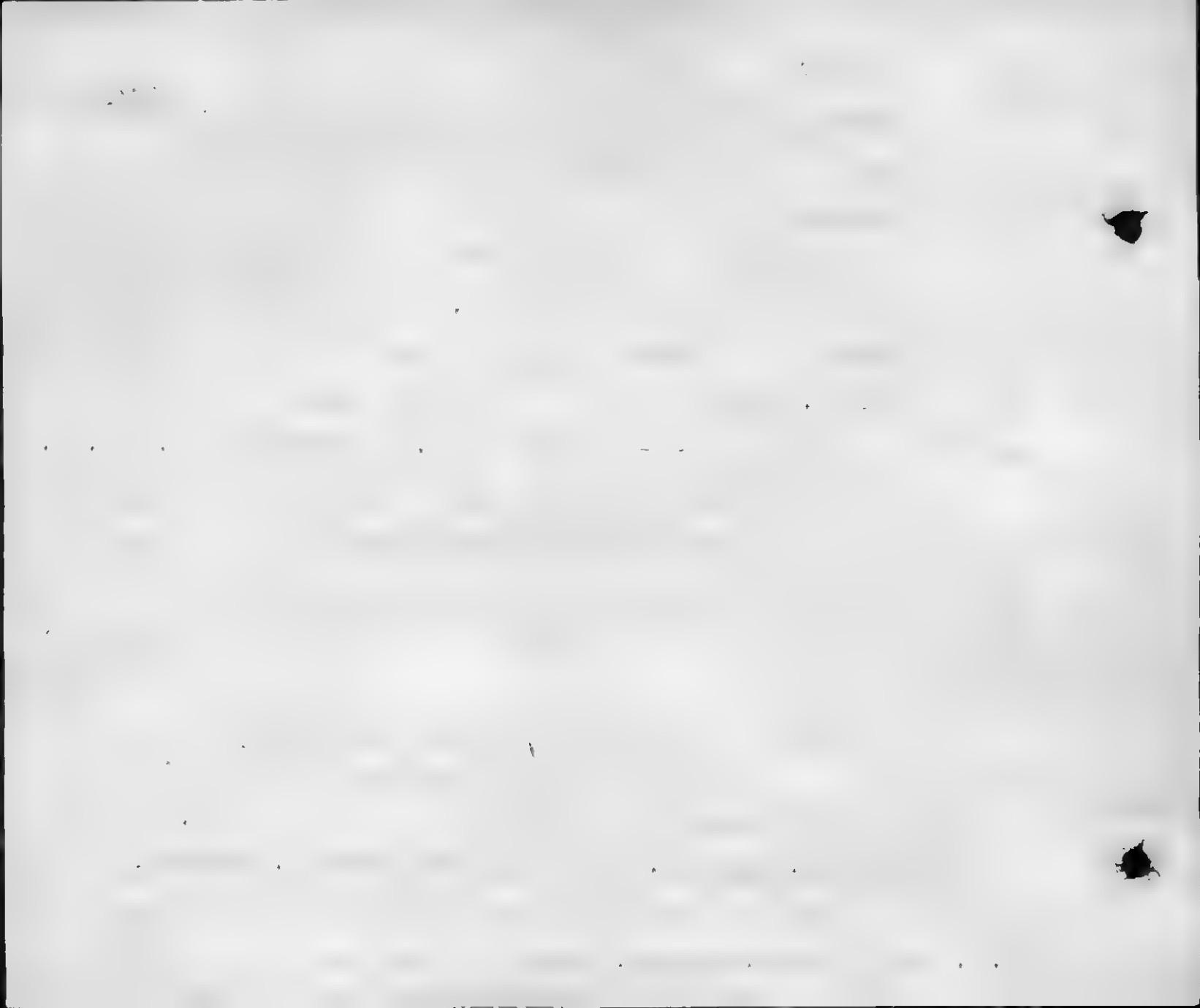
24 FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison and Son, Frederick, Maryland

25a. REC'D BY REGISTRAR

Arthur S. Krause

25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10226

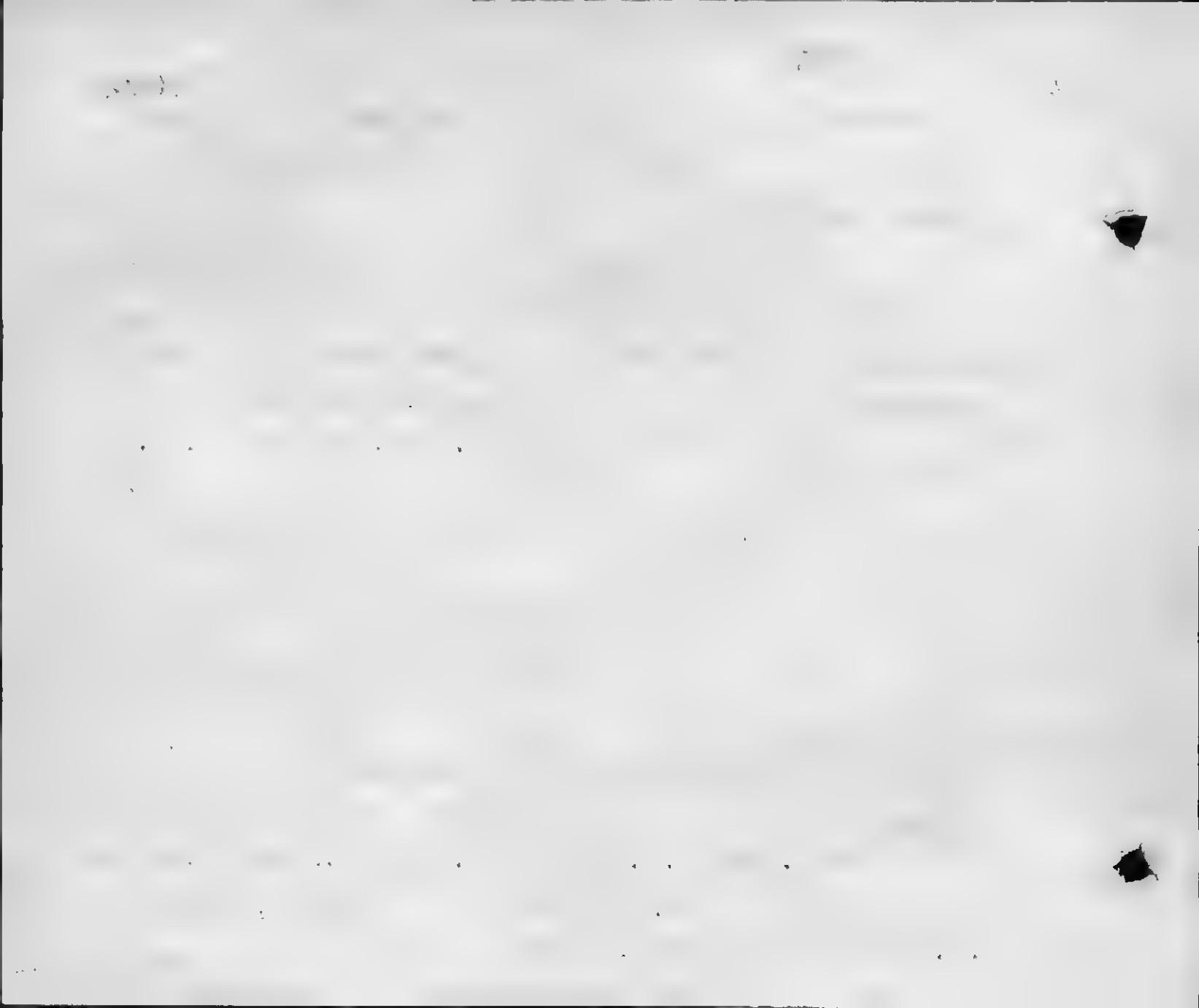
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers; pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60**M****I**

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, state name and admission date) a. STATE MARYLAND b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 9/12/61	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks	
3. NAME OF DECEASED (Type or print) EDGAR		First SEYMOUR	Middle SMITH
4. SEX Male		5. COLOR OR RACE White	6. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
7. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 Jan 1886	
9.a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Laborer		10.b. KIND OF BUSINESS OR INDUSTRY Rubber Company	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Seymour Smith		14. MOTHER'S MAIDEN NAME Abigail (last name unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 219-20-4311	
17. INFORMANT Charles E. Smith, Point of Rocks, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease of death, the underlying cause (c) 5 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.0 DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Sep 12 , 1961, to Sep 21 , 1961, that (I) (we) last saw the deceased alive on Sep 20 , 1961, and that death occurred 4:20A.M. from the causes and on the date stated above.		22. DATE SIGNED 21 Sept 1961	
22a. SIGNATURE Henry V. Chase		M.D. ATTENDING PHYS. 22d. ADDRESS 4 E. Church St., Frederick, Maryland	MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED 21 Sept 1961
23e. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 9-23-61	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		23d. LOCATION (City, town or county) Woodsboro, Maryland	
		25e. REC'D BY REGISTRAR DATE SEP 22 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10227

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. **TO FEDERAL DIRECTOR:** If the deceased was a member of the U.S. Armed Forces, then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

M

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Utica

MARYLAND

c. LENGTH OF STAY IN lb

44 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Own Home

3. NAME OF
DECEASED
(Type or print)

First FANNIE Middle CATHERINE

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Feb. 5. 1885

4. DATE
OF
DEATH

Sept. 27. 1961

Month

Sept

Day

27

Year

1961

e. IS RESIDENCE
ON A FARM?
YES NO

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

9. AGE (In years
from birthday)

76 yrs

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

Hours

Min.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Shryock

14. MOTHER'S MAIDEN NAME

Catherine Anders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give rank and date of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Elmer C. Smith R.F.D.3. Frederick Md

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

Acute myocardial infarction

Arteriosclerotic cardiovascular disease

INTERVAL BETWEEN
ONSET AND DEATH
3 hoursseveral
years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour

a.m.

p.m.

White

Not White

at work

at work

at work

at work

factory street, office bldg., etc.,

(City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 27, 1961, to Sept. 27, 1961, that (I) (we) last saw the deceased alive on Sept. 27, 1961, and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

A. DETTBARN

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

Wallenoville, Md.

22b. DATE
SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL

Burial Sept. 30, 1961 Utica Cem.

23d. LOCATION (City, town or county)

Utica, Fredk. Co. Md.

(State)

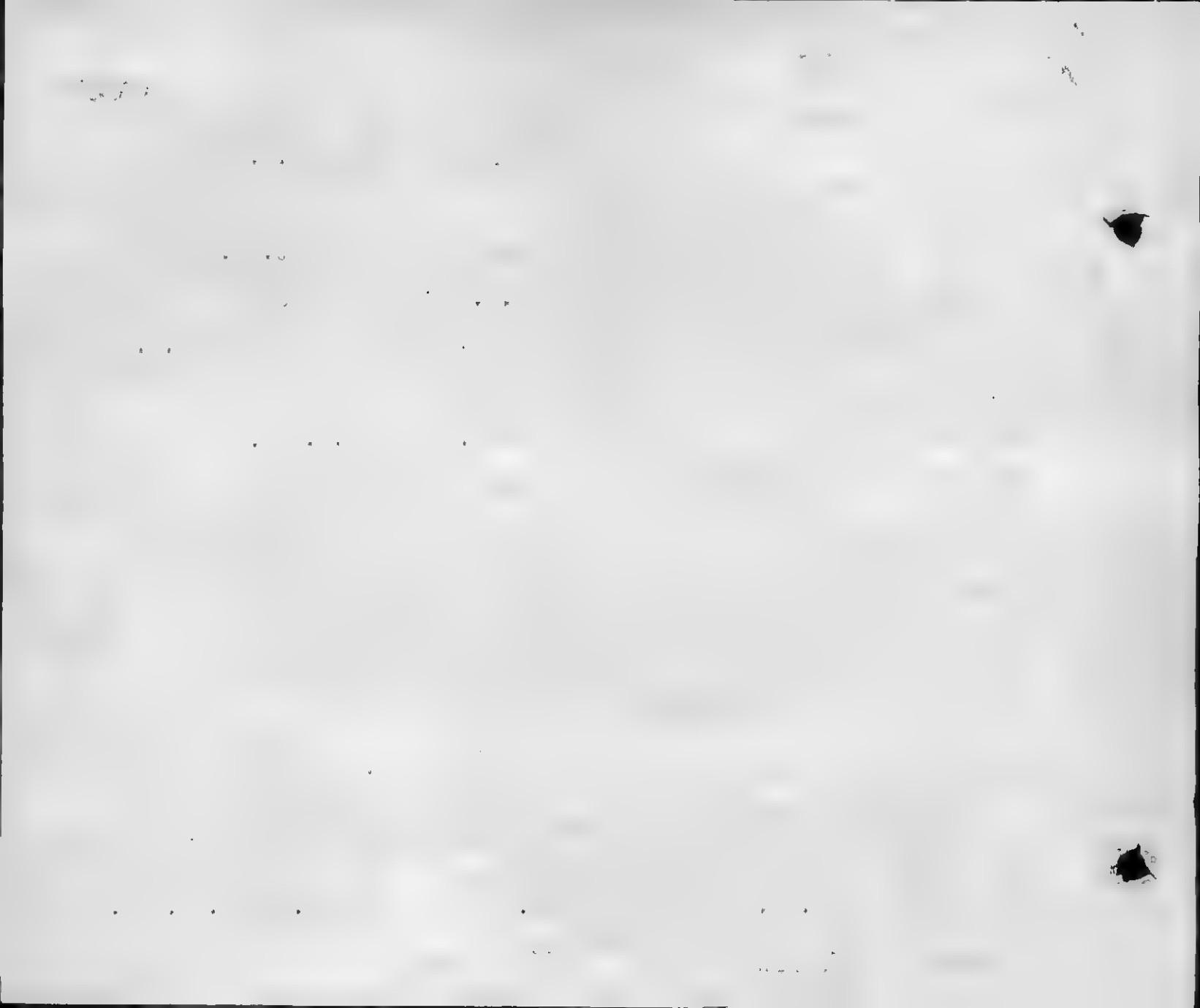
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Raymond E. Creager

Thurmont MD

Oct. 3, 1961

Clyde S. Times



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. You may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



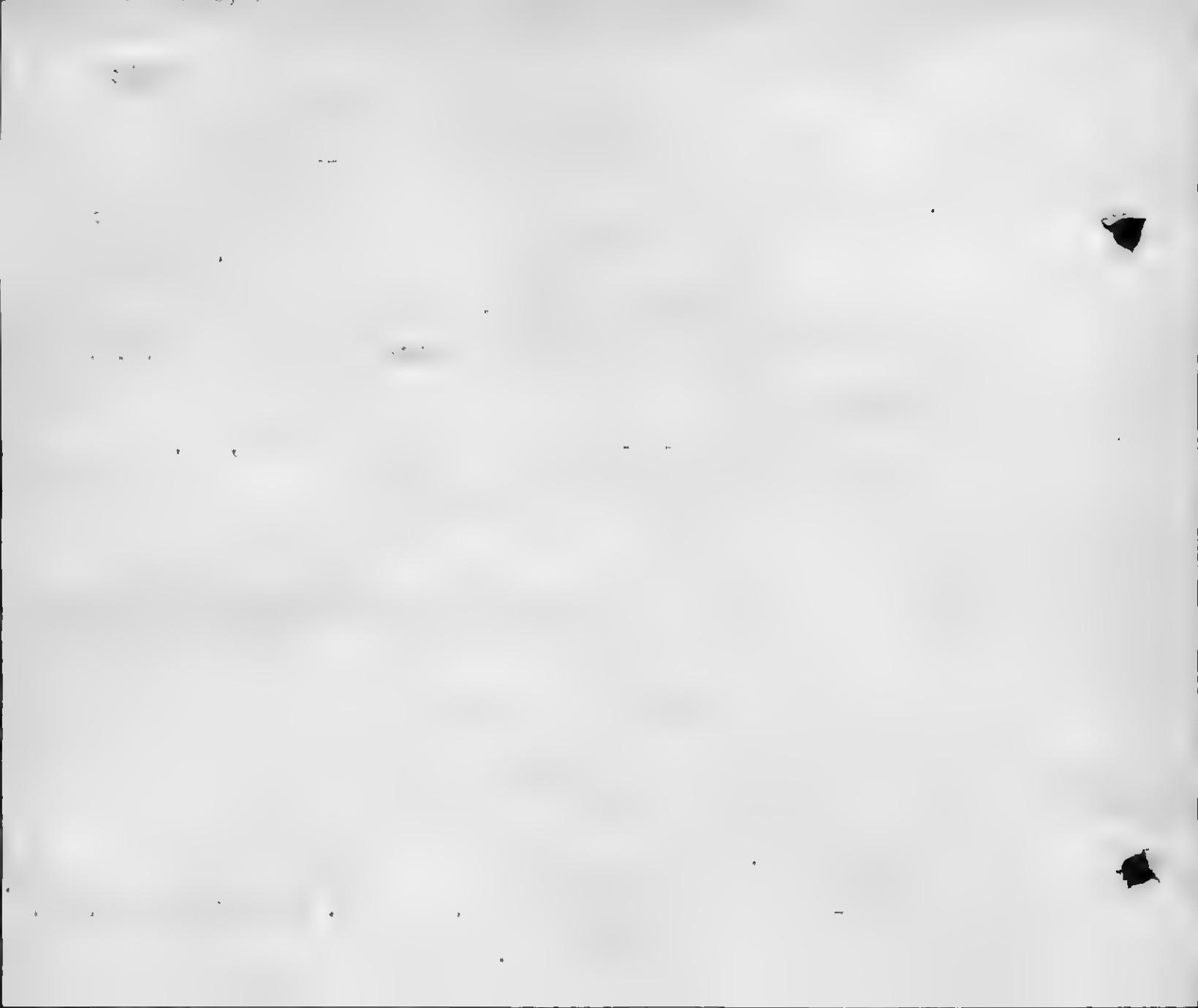
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10228

CERTIFICATE OF DEATH

10223

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
Frederick		Graceham		30		a. STATE	
						Maryland b. COUNTY	
						Frederick	
						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
						X Graceham -- rural	
						d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day
Nora Belle Smith					Sept. 19	19	61
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	
Female		White	WIDOWED	DIVORCED	Oct. 25, 1874	86 yrs.	IF UNDER 1 YEAR Months Dey
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Ohio		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Josiah Hedges				Marie Shaffer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		219-36-4321		Arlie Smith		Graceham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Heart disease Coronary type				1 hour	
420.0		DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Heart disease arteriosclerotic - Chronic					
DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Fracture of hip - old - 7 yrs duration					
20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20f. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED White at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
19		Not White at work					
21. I certify that (I) (this hospital) attended the deceased from _____ May 1954 to Sept 19, 1961, that (I) (we) last saw the deceased alive on Sept 1 1961, and that death occurred at Thurmont, MD, from the causes and on the date stated above.							
22e. SIGNATURE		James K. Gray		ATTENDING PHYS.		MED. DIRECTOR	
22c. PHYSICIAN'S NAME (Type)		James K. Gray		STAFF PHYS.		<input type="checkbox"/>	
				22d. ADDRESS			
						Thurmont, Maryland	
23e. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)	
Burial		9-22-61		Charlesville Cem.		Md. Nr. Frederick Fred. Co.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25e. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Faymon F. Siegel		Thurmont, Md.		DATE SEP 21 '61		Cilia S. Thorne	



1
FOR STATE
HEALTH DEPT.

M

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delayed, please initial the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10229

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10224

1. PLACE OF DEATH

b. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

corner Winchester St. & Clarke Pl.

3. NAME OF
DECEASED
(Type or print)

Firs.

Middle

5. SEX

Raymond

I. Smith

Male

White

WIDOWED

DIVORCED

b. DATE OF BIRTH

June 15- 1888

1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Brick Works

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

George Washington Smith

TS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

214-10-2998

Mrs. Elmer Hargett- Frederick- Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
Minutes


Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

B.O.Thomas

CHIEF MEDICAL EXAMINER

DATE SIGNED

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Sept. 2-1961

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country) (State)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

24a. REC'D BY REGISTRAR (State)

24b. REGISTRAR'S SIGNATURE

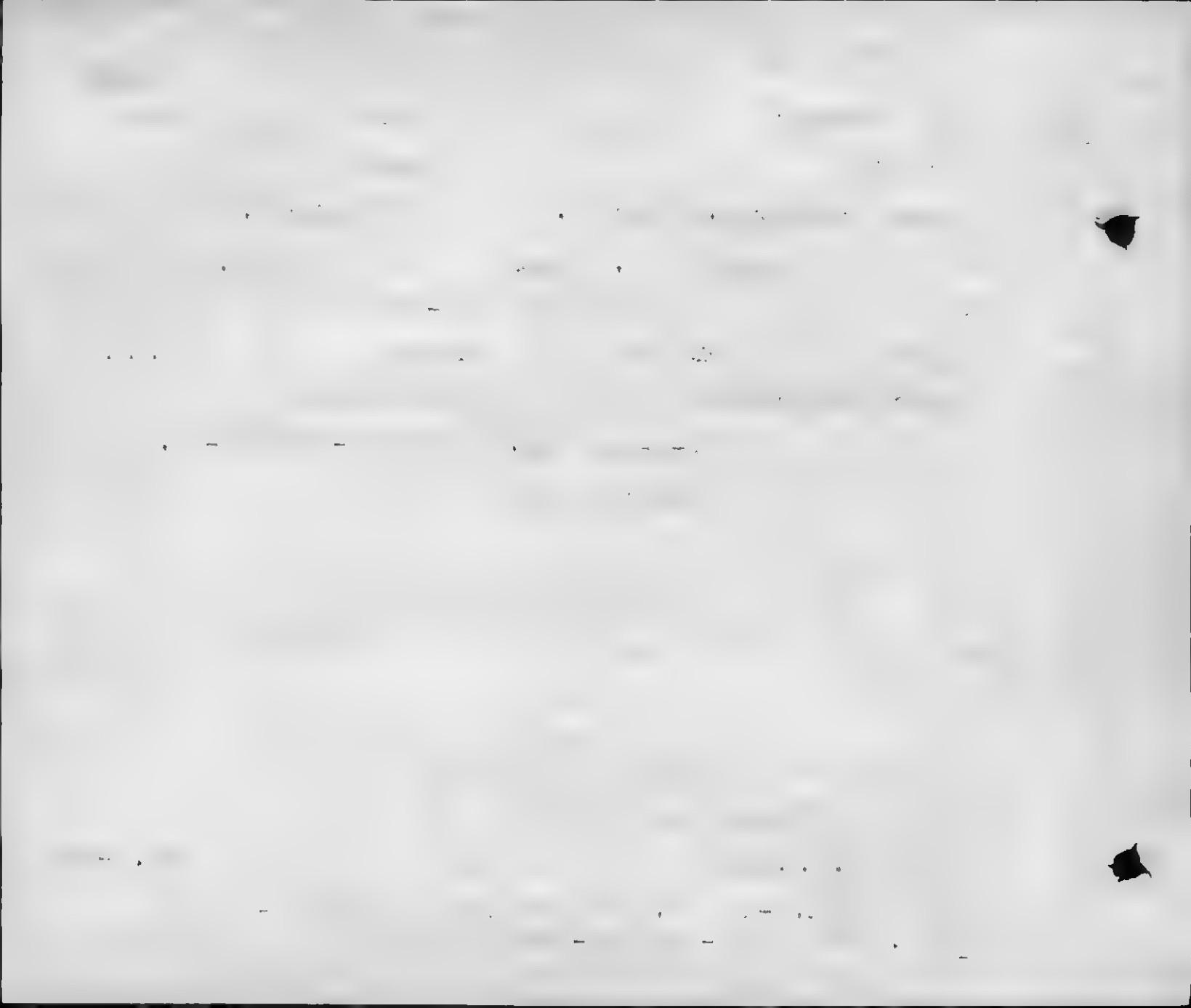
23. FUNERAL DIRECTOR

Robert E. Dailey and Son- Frederick- Maryland
by- E. J. Whitmore

ADDRESS

SEP 6 '61

Carroll S. Knave



FOR STATE
HEALTH DEPT.

M

TO DEATH: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in bold in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10225

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

Walkersville Rd

c. LENGTH OF STAY IN lb

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

September 20 1961

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

B. DATE OF BIRTH

Feb. 15, 1903

9. AGE (in years
last birthday)

48 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Frederick Co

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry M. Staley

14. MOTHER'S MAIDEN NAME

Virgie Michael

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs Virgie Staley Walkersville Md

INTERVAL BETWEEN
ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Strangulation by hanging

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

B. O. Thomas

EXAMINER'S
NAME (Type)

B. O. Thomas, M.D.

DATE SIGNED

Sept 20, 1961

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

(State)

SEP 25 '61

O. L. Thomas

DATE



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Ref. No. 10226
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WINTON		First LEWIS	Middle STOCKMAN	Lost	a. DATE OF DEATH September 4 1961
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1905
9. AGE (In years lost by today) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Jefferson, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David R. Stockman		14. MOTHER'S MAIDEN NAME Clara Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-9768		17. INFORMANT Mrs. James L. Ingram, Jefferson, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812 X		Pulmonary Thrombosis : minutes			
DUE TO Conditions, if any, which gave rise to immediate cause (b) to, stealing the underlying cause lost		Fracture of left leg : 7 days			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) M.V. and pedestrian			
20c. TIME OF INJURY Month, Day, Year Hour 8 25 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 340	
20f. (City or town) Jefferson Frederick, Md		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.D.Thomas		DATE SIGNED 9/8/61			
EXAMINER'S NAME (Type) B.D.Thomas, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-1961		22c. NAME OF CEMETERY OR CREMATORIUM St. Luke's Cemetery	
22d. LOCATION (City, town, or county) Feagaville, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 11 '61	
				24b. REGISTRAR'S SIGNATURE J. Etchison	
VS. A1SME 5M 2/57					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH				10227			
1. PLACE OF DEATH a. COUNTY <i>Frederick</i>				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>				b. COUNTY <i>Frederick</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. LENGTH OF STAY IN 1b <i>1</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Finksburg</i>				d. STREET ADDRESS <i>Box 169</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <i>Baby</i>				First <i>Baby</i> Middle <i>Bay</i> Last <i>Thompson</i>				4. DATE OF DEATH Month <i>September</i> Day <i>19</i> Year <i>61</i>											
5. SEX <i>Male</i>				6. COLOR OR RACE <i>Black</i>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>September 5, 1961</i>				9. AGE (In years last birthday) yrs. <i>1</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>Gilbert Wootton</i>				14. MOTHER'S MAIDEN NAME <i>Ruth Ann Thompson</i>				15. Address <i>Mother Ruth Ann Thompson Box 169 Finksburg</i>											
16. SOCIAL SECURITY NO.				17. INFORMANT				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO <i>776X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				19. INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)				20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>9-5-61</i> to <i>9-5-61</i> , that (I) (we) last saw the deceased alive on <i>9-5-61</i> , and that death occurred at <i>545</i> M, from the causes and on the date stated above.				22a. SIGNATURE <i>J. P. Poirier</i>				22b. DATE SIGNED <i>9-5-61</i>				22c. PHYSICIAN'S NAME (Type) <i>J. P. Poirier</i>				22d. ADDRESS <i>801 7th Street Frederick</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>				23b. DATE THEREOF <i>9/6/61</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>Frederick Memorial Hospital</i>				23d. LOCATION (City, town, or county) (State) <i>Frederick Md.</i>							
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. David Youngdahl</i>				ADDRESS <i>Frederick, Md.</i>				25a. REC'D BY REGISTRAR <i>SEP 8 '61</i>				25b. REGISTRAR'S SIGNATURE <i>✓ - 8 hours</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10233

CERTIFICATE OF DEATH

10228

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence to be indicated) b. STATE <i>Maryland</i>	
c. LENGTH OF STAY IN 1b RURAL and give nearest town) <i>Rural - Lewisburg</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Lewisburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
II NAME OF DECEASED (Type or print)		First <i>HOWARD</i>	Middle <i>MELVIN</i>
Last <i>WAGNER</i>		4. DATE OF DEATH <i>Sept. 14 1961</i>	Month Year
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Sept. 26 1878</i>		9. AGE (In years last birthday) <i>82 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY (If none, state or foreign country) <i>own farm</i>	12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Grafton Wagner</i>		14. MOTHER'S MAIDEN NAME <i>Elisabeth Dudson</i>	Address <i>Mrs Virginia Wagner, R-1 Thurmont Md.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-32-5382</i>	17. INFORMANT <i></i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Atherosclerosis of heart blood vessels</i>		1 year	
(c) DUE TO <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 15 1961</i> to <i>Sept 14 1961</i> , that (I) (we) last saw the deceased alive on <i>Aug 10 1961</i> , and that death occurred at <i>2pm</i> , from the causes and on the date stated above		22b. DATE SIGNED	
22a. SIGNATURE <i>James K. Gray</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>James K. Gray</i>		22d. ADDRESS <i>Thurmont - Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/16/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Chapel cemetery</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Barton, Walkersville, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>SEP 18 '61</i>
			25b. REGISTRAR'S SIGNATURE <i>O. L. H. & Hause</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

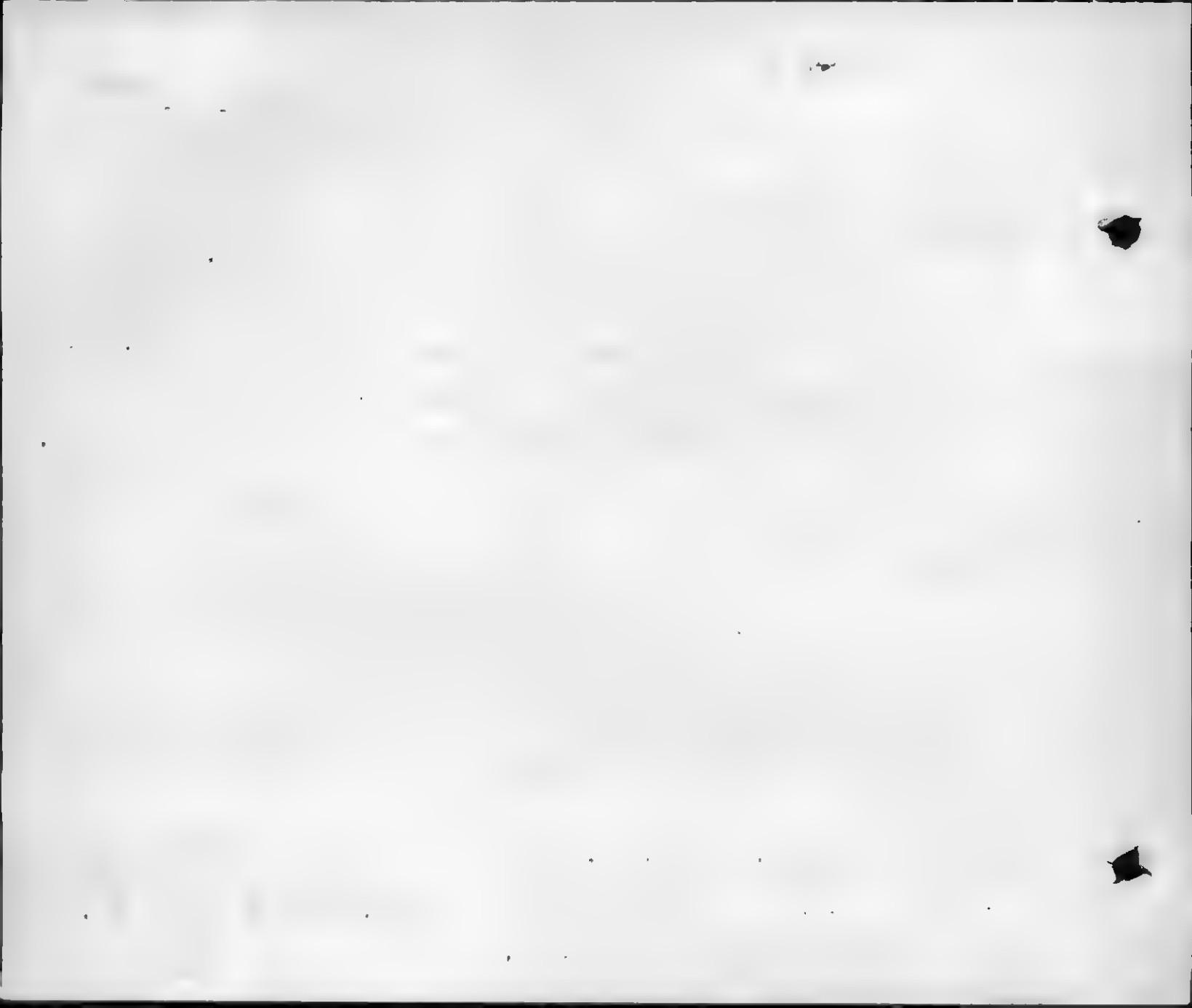
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10234

10229

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence a. STATE Maryland) b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown	c. LENGTH OF STAY IN 1b Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Webster
4. DATE OF DEATH Sept. 5	Month Sept.	Day 5	Year 19 61
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1862
9. AGE (in years last birthday) 99	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Gonso	14. MOTHER'S MAIDEN NAME Charlotte Kolb		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Miss Charlotte Webster	Address Lewistown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, general			
DUE TO Arteriosclerosis, general			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Father had hip removed & healed			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) White not while at work		
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/5 to 19/5 , 19 61 , that (I) (we) last saw the deceased alive on 9/5 , 19 61 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James E. Stoner, Jr.	22b. DATE / SIGNED 9/5/61		
22c. PHYSICIAN'S NAME (Type) James E. Stoner, Jr.	22d. ADDRESS WALKERSVILLE, MD.		
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 9-8-61	23c. NAME OF CEMETERY OR CREMATORIAL Rocky Springs Union Cem. Frederick RD	23d. LOCATION (City, town, or county) (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond S. Greager		ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR DATE SEP 7 '61
			25b. REGISTRAR'S SIGNATURE Charles S. Thomas



12

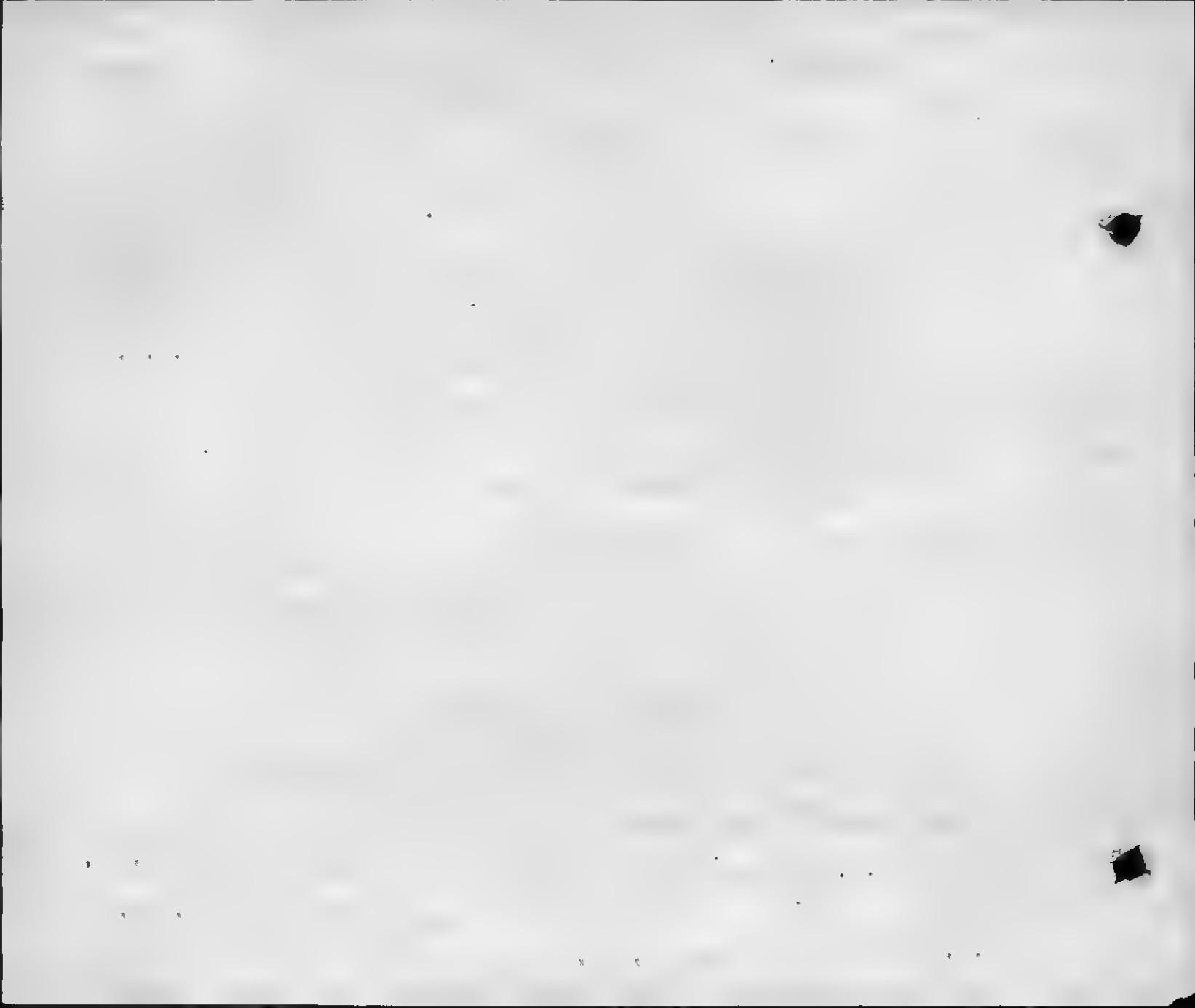
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10230

1. PLACE OF DEATH		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before adm' ssion)						
a. COUNTY Frederick		c. LENGTH OF STAY IN lb hours		a. STATE Maryland		b. COUNTY Frederick				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Etta Vivian West		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX Female		6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-18- 1897		9. AGE (in years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cannery Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles Brown		14. MOTHER'S MAIDEN NAME Etta Temple		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) no		16. SOCIAL SECURITY NO. 219-07-4920		17. INFORMANT Russell West		Address Baltimore, Md 1732 N. Smallwood St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. Hypertension		DUE TO (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g., Hypertension)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 hrs
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE B. D. Thomas		NAME (Type) B. D. Thomas		-Professional Bldg. Address (Street, city, town, or county)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-25-61
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-61		22c. NAME OF CEMETERY OR CREMATORIAL Bartonsville		22d. LOCATION (City, town, or country) Frederick Co., Md.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23. FUNERAL DIRECTOR C.E. Hicks III		ADDRESS Frederick, Md.		24e. REC'D. BY REGISTRAR SEP 27 '61		24f. REGISTRAR'S SIGNATURE Charles S. Kline				
VS. A15ME 5M 7/59				DATE						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10236

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

MARYLAND

7 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF DECEASED
(Type or print)

Harry

Middle

5. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farming

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

December 24, 1891

9. AGE (In years last birthday)

70 yrs.

10b. KIND OF BUSINESS OR INDUSTRY

Farming

11. BIRTHPLACE (County & State, or foreign country)

Frederick County

13. FATHER'S NAME

John E. Wiles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank or grade and service)

No No

16. SOCIAL SECURITY NO

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

REMITTANT CAUSE (b)

INDIRECT CAUSE (c)

14. 11X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.

15. DUE TO (b)

16. DUE TO (c)

215-36-7055

Paul E. Wiles Frederick Route #7, Maryland.

Bilateral pneumonia

Staphylococcal infection

INTERVAL BETWEEN
ONSET AND DEATH
2 weeks

2 weeks

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 1960, to Sept 26, 1961, that (I) (we) last saw the deceased alive on Sept 26, 1961, and that death occurred at 11:15 P.M. from the causes and on the date stated above.

22. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

E.A. Dettbarn M.D.

M.D.

ATTENDING PHYS.
22d. ADDRESS

MED. DIRECTOR
STAFF PHYS.

22b. DATE SIGNED
Sept 27 1961

Walkersville, Maryland.

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

9/29/61

23c. NAME OF CEMETERY OR CREMATORIAL

Middletown Lutheran Cem.

23d. LOCATION (City, town or county)

Middletown

(State)

Md.

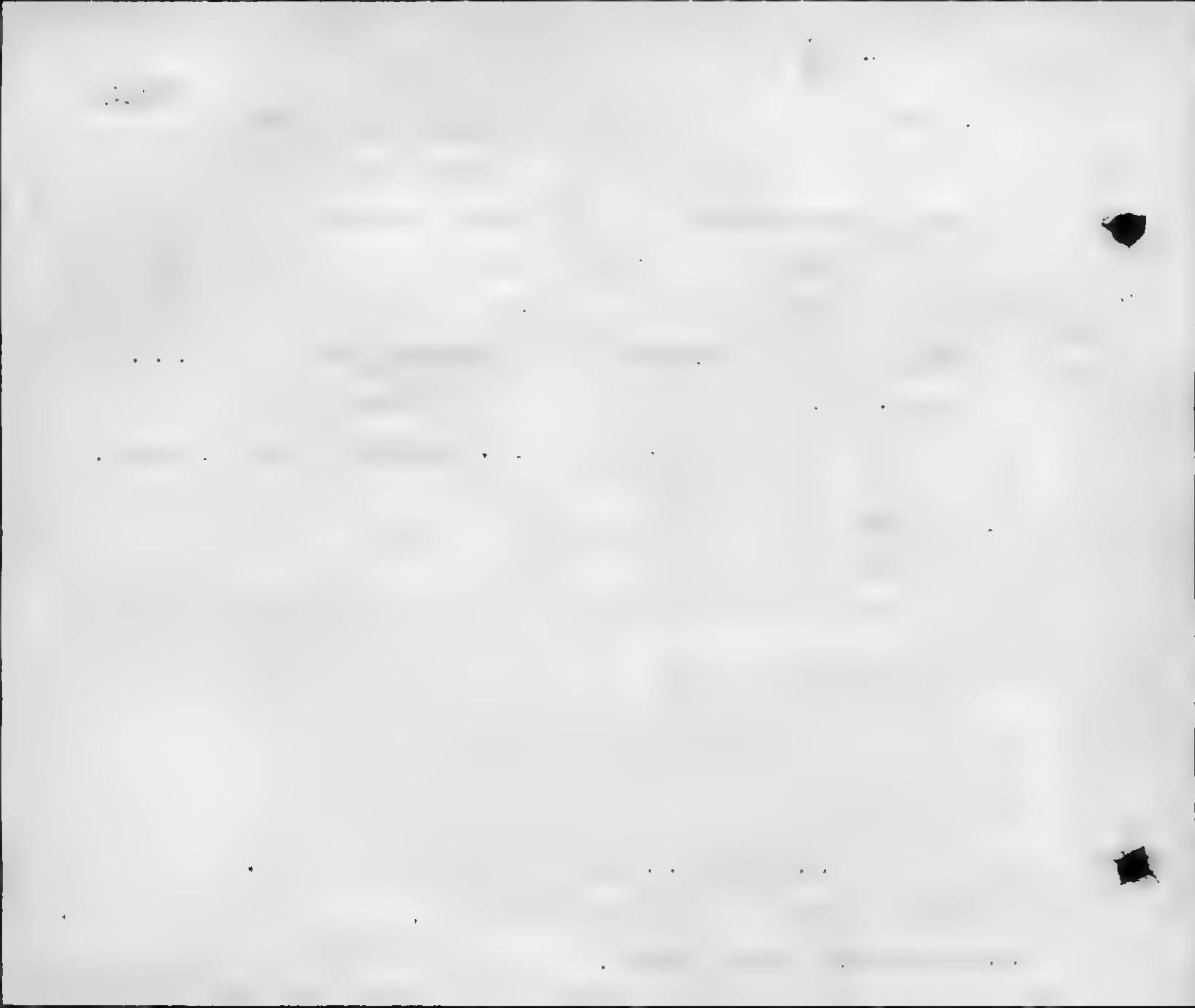
24. FUNERAL DIRECTOR'S SIGNATURE

M.R. Etchison & Son, Frederick, Maryland.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE SEP 29 '61

Cathleen S. Thomas



X 1
M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Be 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10237

10232

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick-Rural-R.F.D.#5

c. LENGTH OF STAY IN 1b

2 Years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Vindabona Convalescent and Rest Home

**3. NAME OF DECEASED
(Type or print)**

JOHN

McELROY

4. SEX

5. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman-Retired

13. FATHER'S NAME

Nathaniel John Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank and date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

220-05-6083 Mr. N. John Wilson

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last. (b)

DUE TO

cause last. (c)

Cerebral Thrombosis
Cerebral Arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

instant

1 year

Ann Sophia Albaugh

14. MOTHER'S MAIDEN NAME

Address

509 Magnolia Avenue,
Frederick, Maryland

USA

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19' 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Whila Not Whila
at work at work

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from... 9-1-1961, to 9-1-1961, that (I) (we) last saw the deceased alive on... 9-1-1961, and that death occurred at 4:40A from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

T. E. Stone, M. D.

M. D.

ATTENDING PHYS MED. DIRECTOR STAFF PHYS
22d. ADDRESS

West Third Street, Frederick, Maryland

22b. DATE
SIGNED
9/11/1961

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial Sept. 13, 1961

23c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

23d. LOCATION (City, town or county)

Frederick,

(State)

Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Maryland

25a. REC'D BY REGISTRAR DATE SEP 13 '61

25b. REGISTRAR'S SIGNATURE
Curtis S. Kraus

82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10239		10234	
1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission] a. STATE Md. b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK Mem. Hosp		e. STREET ADDRESS 1511 EAST "D"	
3. NAME OF DECEASED (Type or print) LENA		4. DATE OF DEATH Month Sept Day 15 Year 1961	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14/16 9. AGE (In years last birthday) 45 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRICE ELECTRIC		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OKLAHOMA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LEE LUCAS		14. MOTHER'S MAIDEN NAME Ruth ALGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. L.W. YOUNG, Brunswick, Maryland	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Brownsville (County) Maryland (State)	
21. I certify that (I) (his/hospital) attended the deceased from 15 Sept 1961 to 15 Sept 1961 , that (I) (not) last saw the deceased alive on 15 Sept 1961 , and that death occurred 6:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE JR Poirier		M.D. <input type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN	
22c. PHYSICIAN'S NAME (Type) JR Poirier		22d. ADDRESS 801 Toll House Ave, FREDERICK	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL 9/18/61		23b. DATE THEREOF 9/18/61 23c. NAME OF CEMETERY OR CREMATORIAL BROWNSVILLE HEIGHTS	
24. FUNERAL DIRECTOR'S SIGNATURE Bible Feets Brunswick, Md		25a. LOCATION (City, town, or county) BROWNSVILLE, Maryland (State)	
		25b. REC'D BY REGISTRAR DSEP 21 '61	
		25b. REGISTRAR'S SIGNATURE Wm. S. Frame	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1023

CERTIFICATE OF DEATH

10233

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
Frederick		b. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b			
Frederick		X Frederick, Route #2.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					
Evergreen Point, Frederick, Md.					
3. NAME OF DECEASED (Type or print)		First	Middle		
Bertha		Blank	Winpigler		
4. SEX		5. COLOR OR RACE			
Female		White			
6. MARRIED		7. NEVER MARRIED			
WIDOWED		DIVORCED			
8. DATE OF BIRTH		9. AGE (In years last birthday)			
September 23, 1899		62 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			
Housewife		Housewife			
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Frederick County		U.S.A.			
13. FATHER'S NAME					
William Blank					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.			
No		(If yes, give rank or grade of service)			
17. INFORMANT		Address			
Alden A. Floor, 106 Catoctin Ave, Frederick, Md.					
18. CAUSE OF DEATH [Enter only one cause, designating for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
420.1					
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first.					
DUE TO (b) Coronary Occlusion due to Myocardial Ischemia					
DUE TO (c) Coronary Sclerosis & Myocardial Ischemia					
INTERVAL BETWEEN ONSET AND DEATH 5 mo					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				Sept 23, 1961, Jefferson, Maryland	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 23, 1961</u> , to <u>Sept 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 23, 1961</u> , and that death occurred at <u>M.D.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>A. Talbott Brice, M.D.</u>				22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type)	
A. Talbott Brice, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/1/61	
23c. NAME OF CEMETERY OR CREMATORIAL Lutheran				23d. LOCATION (City, town or county) Middletown, Maryland. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland.				ADDRESS	
				25a. REC'D BY REGISTRAR OCT 2 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10240

10235

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 316 Jefferson Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
f. STREET ADDRESS 316 Jefferson Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle REBECCA	Last ZIMMERMAN
4. DATE OF DEATH	Month September	Day 30	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1869
9. AGE (In years lost birthday) 92 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY House-work	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Shuff	14. MOTHER'S MAIDEN NAME Rebecca Russman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Charles E. Zimmerman (Same as item #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Congestive Heart Failure, acute INTERVAL BETWEEN ONSET AND DEATH 1-2 hr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerotic Heart Disease 5 yrs. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 10, 1961 , to Sept. 30, 1961 , that (I) (we) last saw the deceased alive on Sept. 28, 1961 , and that death occurred at 4:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Henry V. Chase	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/30/61
22c. PHYSICIAN'S NAME (Type) Henry V. Chase	22d. ADDRESS 4E Church St Frederick Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-3-1961	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery	23d. LOCATION (City, town, or county) Frederick (State) Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DACT 2 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

